**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

**CERTIFICATE OF NEED (CON) COMMISSION MEETING**

**TUESDAY, JUNE 10, 2003**

Holiday Inn West Lansing Conference Center
7501 West Saginaw Hwy.
Delta Conference Room
Lansing, Michigan

***APPROVED TRANSCRIPT (MINUTES)***

**MEMBERS PRESENT:**

Renee Turner-Bailey, Chairperson
Jack Smant, Vice Chairperson
Peter Ajluni, D.O.
Richard Breon
Bradley Corey
James K. Delaney
Edward B. Goldman
Norma Hagenow
James E. Maitland
Michael Sandler, M.D.
Michael Young, D.O.

**DEPARTMENT OF ATTORNEY GENERAL STAFF PRESENT:**

Ronald J. Styka

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH STAFF PRESENT:**

William J. Hart, Jr.
Larry Horvath
Brenda Rogers
Jan Christensen

**GENERAL PUBLIC ATTENDANCE:**

There were approximately 91 people in attendance.

Commencing at or about 10:05 a.m.

MS. TURNER-BAILEY: Good morning. Welcome to the June 10th meeting of the Certificate of Need Commission. I'm calling the meeting to order. It's 10:05 a.m. At this time, I would like to ask everyone to take a review of the -- I think I have a little too much feedback -- take a look at the agenda. I'm looking at an old agenda, so I should probably look at a new one. Any corrections or changes, additions to the agenda? Commissioner Sandler.

DR. SANDLER: Yes. I have a comment to make on number seven, same on the new and old, Renee. I think that's the same.

MS. TURNER-BAILEY: Yes, it is.

DR. SANDLER: My comment is based on the distribution of E-mail. It's based on the E-mails from the assistant attorney general, his reservation, and Mr. Styka has distributed. Item number seven in the agenda indicates that Commission action of -- Section 22209(3) of PA 368, as amended, and calls for a Commission action on that. However, we've been advised in the June 9th written memorandum that it is illegal for the Commission to vote prior to the June 15th deadline provided by the Legislature. There is actually one key paragraph in the June memorandum I'm going to call to the attorney general. I understand why this was on the agenda, because the June 9th agenda is only less than one day old and the -- this was already -- the agenda was already distributed, and the E-mails just came out yesterday from the attorney general. However, I would like the attorney general to summarize his E-mail that was sent to the Commission, which is his memorandum of June 9th. And I think he should state as to the possible difficulties if we were to act under 22209. Ron, please.

MS. TURNER-BAILEY: Could I just ask -- that's not really a change in the agenda. That's bringing up an agenda item earlier than it's stated.

DR. SANDLER: I don't believe it belongs on the agenda is why I'm bringing it up now.

MR. SMANT: If the intent is to not have comment from all the people who have come down here to make comments, I do think that we would be doing a disservice not only to those who came down here but to the Commission. Part of our role is to elicit input and to hear what is to be said. At our last meeting, if you remember, we had the same legal opinion except for basically the last one is more strongly worded. And the process we used there was to allow the comment and then address it after the comments were held. There is room in this at the time we have Commission action to, in fact, discuss whether or not we're going to vote, whether we wish to vote. And I would hope that that's the time that we would have a legal discussion. I would the urge the Commission not to take a position now that would render all the people's comments or ability to comment useless today. I think we'd be doing a great disservice.

DR. SANDLER: If that's what the commissioners accept and the chair wishes, I don't have a problem with that, except my response could be that to make precisely the same comments on the standard that we were talking about, which is basically the same issue, if the Commission chair and vice chair want to have it handled in that matter, I don't have a problem with it. How does that sound?

MR. SMANT: Fine.

MS. TURNER-BAILEY: Are there any suggestions or changes, additions? Brenda, were you going to make a comment?

MS. ROGERS: I was just going to clarify that you could look at that Commission action to be any type of action. That could be action to decide not to take a vote. So really I think it's wide open.

MS. TURNER-BAILEY: There's no motion at this point.

MR. MAITLAND: I move the agenda be approved as presented.

MS. TURNER-BAILEY: I was going to say that there's a note on the agenda today that says public testimony will be limited to five minutes. Health systems will be allowed two speakers. Two clarifications on that point. The first one is it's not just health systems that I want to limit to two representatives. So any organization, please limit your comments to two speakers. And since I am not always aware of which organizations belong with which systems, I'm going to ask that we work on the honor system as far as limiting it to those two. And having said that, is there -- yes, Brenda.

MS. ROGERS: Just to clarify -- again, this is Brenda Rogers. As you come up to speak today, if you would please state your name, where you are from. And we do have a sheet at the podium, if you could please print

your name. Also, a reminder to the commissioners as well, as you're speaking today, could you please identify yourselves for the court reporter. Thank you.

MS. TURNER-BAILEY: With those clarifications, any further discussion on the agenda? All in favor signify by saying aye. (Whereupon all affirm.)

MS. TURNER-BAILEY: Opposed? The agenda is approved. I think that sort of sets the tone for the day, doesn't it? It took seven minutes to approve. Next on the agenda, declaration of conflicts of interest. This would be the time to declare any conflicts of interest. Mr. Goldman.

MR. GOLDMAN: I have a conflict of interest because the university has an interest in the application of a Certificate of Need.

MS. TURNER-BAILEY: Thank you.

MR. GOLDMAN: Because I'm employed by the university, I would like to declare the conflict, and I would like to refrain from any voting when we reach that item.

MS. TURNER-BAILEY: Commissioner Sandler.

DR. SANDLER: Commissioner Sandler. I am an employed physician of the Henry Ford Health System. I'm not sure that's a conflict since I would have no financial gain or loss in any of the agenda items.

MS. TURNER-BAILEY: Thank you. Commissioner Breon.

MR. BREON: Yes. Commissioner Breon. I have a conflict of interest on the CT discussion on transfer of ownership. We have a pending CON.

MS. TURNER-BAILEY: For those items on the agenda, we haven't gotten there. We're going to look at how our time is going with some of these items. There's no action required today. We'll make a decision as we get further into the day as to whether we need to move those further to the work plan. I don't know if that's going to happen or not, how we're going to move forth. Everybody received a copy of the minutes from the May 22nd -- May 28th special meeting of the Commission. Are there any corrections, additions, changes? Since they're transcript form, I can't imagine. But I'll have to give you that opportunity.

MS. HAGENOW: Moved.

MS. TURNER-BAILEY: Moved by Commissioner Hagenow that the minutes be approved.

MR. BREON: Support.

MS. TURNER-BAILEY: Supported by Commissioner Breon. All in favor signify by saying aye. (Whereupon all affirm.)

MS. TURNER BAILEY: Opposed? Motion carries. Hospital beds, relocation of beds between hospitals within the same subarea. Brenda, would you like to walk us through that, please.

MS. ROGERS: Again, this is Brenda Rogers. In your packet, you will find a memo that summarizes the language that you are about to take final action on today if you decide to do so. On the hospital beds, what this is going to allow is for the relocation of existing licensed hospital beds from one existing licensed hospital to another existing licensed hospital within the same subarea. There are no ownership requirements involved with this. The department does have a couple of technical amendments. If you look at page nine -- excuse me. Page three is the first amendment. Section 2(1)(W), sections 9(1) -- let me see here. I'm sorry. This is a note that if this language is approved today -- the language under the project delivery requirements under section 9(1)(B)(i) and (ii) would no longer be necessary if this language is approved today. Remember we had language that went into effect just in May, and there is some carryover language that we talked about at the last Commission meeting that would be stricken if this is moved forward today. That's one of those items, and

we would offer that as an amendment. The other change would be section 8(2)(a-f) as currently in the language, that would be stricken. Again, the new section 2 that you're voting on final action today would replace that language which was effective on May 12th. And, again, also going now to section 9(1)(B)(i) and (ii), given that section 8(2) is being replaced, those sections would no longer be necessary if we take final action today. So those would be three technical amendments to these changes that the department would like to suggest. And if you have any further questions, we would be happy to answer them.

MS. TURNER-BAILEY: Any questions?

MR. SMANT: Commissioner Smant. That's in addition to what we received at the last meeting?

MS. ROGERS: The changes are already in the document that you received for today's meeting. So those changes are already incorporated.

MR. SMANT: So today's document is different than the one we had on the 28th?

MS. ROGERS: Yes.

MR. SMANT: So we have not had a chance to review that list.

MS. ROGERS: You received it in your packet last week.

MR. SMANT: But today is not -- that's my question. Today is in the language of the packet or it is not?

MS. ROGERS: It is in the language of the packet; yes.

MR. SMANT: Thank you.

MS. TURNER-BAILEY: Are there any Commission questions for Brenda from the commissioners? Okay. Hearing none. I have several comment cards. James Falahee.

MR. FALAHEE: Thank you for letting me speak to you this morning very briefly, Commissioners. My name is James Falahee. I'm the senior vice president of legal and legislative relations with Bronson Healthcare Group in Kalamazoo, Michigan. I'm also a member of the Ad Hoc Bed Committee that's been meeting for the last, some would say 200 years, some would say two years. We strongly support the language that you have before you right now, and we've supported it for many reasons. I would just like to explain the facts that exist in Kalamazoo. As I testified to this Commission about a year ago, a little over a year ago, crowded hospitals, overcrowded hospitals aren't just a Detroit issue. In our case, in Kalamazoo, there are five hospitals in our subarea. Bronson has two of them; Borgess has two; and there's another hospital, Lakeview. Bronson built a brand new hospital that opened in 2000. That hospital is already underbedded. We are crowded. We are overcrowded. We are right now operating in an occupancy base on licensed beds of 75 to 76 percent. Even with that, we have been on divert. That means we have to close our emergency room doors to ambulance traffic. In the first four months of this year, we were on divert 563 hours. That's about 22 percent of the time that we're on divert. We were on divert again last week and last weekend. I know that our friendly competitor in town, Borgess, was also on divert, because there are times when both of our tertiary hospitals in Kalamazoo are on divert, which means that we both going off of divert. So there are times that patients want to come in via ambulance and can't. And it's not just ambulance traffic. When we are on divert, patients from referring hospitals from as far as 40 or 50 miles away, their attending physician will call us and say, can I get my patient into Bronson. Answer, no, because we're on divert. We need more beds. We are also -- I think you need to be aware of this. Bronson is the highest Medicaid percentage hospital outstate Michigan. Our Medicaid percentage varies between 19 and 20 percent depending on the economy. Right now we're pushing 20 percent of our business is Medicaid. That said, what we would like to do is use this language to transfer beds to Bronson Methodist Hospital, 20 percent Medicaid, from our smaller facility in Vicksburg, Michigan. We would transfer beds from one hospital to another hospital in the same subarea. I presented this issue to this Commission before. We presented it at the ad hoc committee. We've had several discussions at the ad hoc committee about it. The ad hoc committee approved it last February, I believe. Public comments were taken earlier this spring. All of the comments at the public comment period were favorable. So I would ask you to

strongly -- we strongly support it. I would ask you to approve it to alleviate the patient care load and put beds where the patients want to go. Thank you. And I'd be glad to entertain any questions.

MS. TURNER-BAILEY: Any questions? Thank you. James Ball.

MR. BALL: Good morning. My name is James Ball. I'm with -- I'm assistant director of healthcare plans for General Motors Corporation and serve as chair of the hospital bed ad hoc. Just briefly, I have no prepared comments this morning. But I briefly wanted to urge your adoption of the proposed change in standards. As you recall the section being replaced earlier, the ad hoc had adopted or recommended for your adoption standards which would have allowed for hospital-to-hospital transfer of beds within a subarea that would also involve deproliferation, if you will, in the sense that the transferring hospital would have delicensed the remaining beds and reduced the capacity in the area. When the revision came before us, it did not have the same amount of unanimous support that the earlier action did. However, the ad hoc did reach consensus and did report the matter out to you. And we would urge your adoption today.

MS. TURNER-BAILEY: Thank you. Any questions? Thank you. Ken Trester.

MR. TRESTER: Good morning. My name is Ken Trester. I'm vice president of planning -- senior vice president of planning for Oakwood Healthcare in Dearborn, Michigan. And I'm here to strongly support the proposal that hospitals be permitted to move beds within the subarea. We've stated our position previously before this Commission and before the ad hoc committee. In our particular situation, the Oakwood Healthcare System encompasses four inpatient facilities serving western Wayne County and the down-river area. And our story is very similar to my colleagues at Bronson in that our flagship hospital, Oakwood - Dearborn, is experiencing very high occupancies in its medical surgical units. In fact, our occupancies in these units are at least 85 percent almost all of the time, approaching 95 percent and above usually. And that results likewise in some serious access problems to our emergency room. We're on status B, which our diversion of ambulances is about ten percent of the time, and actually status C, which is the emergency room close to ambulances about 15 percent of the time. So this means that about 25 percent of the time for the past year we've had a diversion impact on our emergency room as a result of the availability of beds. We have a very cost-effective way of solving this problem within our system. And that is that our hospital consolidated its psychiatric services to our hospital in Taylor, Heritage Hospital, which resulted in an empty unit, a tenth-floor unit at the Dearborn hospital which could be refitted with at least 50 med-surg beds at a very economical cost. In fact, the cost for the first nursing unit that we would like to put in would even be below the C event threshold per capital. So our plan would be to move a number of the beds that are licensed currently at Heritage, the med-surg beds, to Dearborn, put them there and open the first 32-bed unit and then see how well that alleviates our problem. Eventually, if we needed more beds, we might complete the remainder of that unit. But at this time, we're looking at a 32-bed solution. So we believe that this relocation is very cost-effective, it's in the best interest of the community and that it will vastly improve access to our emergency rooms and most importantly will not add to the bed count in the subarea. We're not requesting additional beds. We're requesting simply to be able to move beds from one institution to the other. So on that basis, we would support this proposal and ask your concurrence. Thank you.

MS. TURNER-BAILEY: Any questions? Thank you. Vin Sahney.

DR. SAHNEY: My name is Vin Sahney. I'm senior vice president of planning and strategy development at Henry Ford Health System. I am here to support this particular bill, but I would like to take this opportunity to point out some of the things when you support this bill you will be supporting. You will be supporting that a hospital which may have less than 50 beds can acquire 200 beds from another hospital and build a brand new facility, which will cost capital costs, which last meeting when we presented moving beds to freestanding facility, Economic Alliance strongly opposed, but they are in support of this bill. You will be moving beds to a facility which does not even have an MRI, a CT scanner, or a laboratory or others, but you will allow it because there's no occupancy requirement in this bill. You will be actually allowing 200 beds, 300 beds to a place which may only have 50 beds with no occupancy. So I just want you to understand what you are voting on even though I'm supportive of this, because I think this is our exact point. So what is a hospital? What is the definition of a hospital? That it has beds. No need for technology in your licensing requirement. So it is possible that you will approve through this legislation that one can move a whole hospital to almost an empty facility with no technology and incur all of the costs that you are so opposed to when we propose that we

should be allowed to move beds to a freestanding facility. So I just want you to think through that, but I'm still in support of this, because I think, in general, this will do good; but I would like to see some requirement for occupancy level, some requirement for some technology in that hospital before transfer of beds were allowed. Thank you.

MS. TURNER-BAILEY: Are there any questions? Thank you. Bob Parrish.

MR. PARRISH: Good morning. I don't have any prepared comments either, but I just wanted to make a few comments in support of the proposal. I am Bob Parrish with the Greater Detroit Area Health Council. We are an organization that has been involved in regional health planning in southeast Michigan for many decades, have long been involved in hospital capacity issues and related kinds of issues in the healthcare field and that part of the world. And as such, we're also a member of the Hospital Bed Ad Hoc Committee that has been meeting for some time and considered this particular proposal along with many others over the last couple of years. I just want to reiterate the support of the Greater Detroit Area Health Council for this proposed modification to the hospital bed standards. It's something that we think provides necessary and appropriate flexibility to the healthcare system and the ability of healthcare organizations to respond to changing circumstances within subareas within the state and, therefore, we think that this is appropriate public policy and will benefit everyone in the community.

MS. TURNER-BAILEY: Are there any questions? Yes, Commissioner Hagenow.

MS. HAGENOW: If you have this much background -- I'm still noodling on what the last speaker said in terms no restrictions on occupancy and technology or no requirements. In your understanding, why would that be? Why was there no restriction? Why was that all stricken out of this particular -- if you were involved in creating this document, why was there no restrictions put in for the requirements of technology and occupancy?

MR. PARRISH: I think that -- I'm not going to speak on behalf of the Hospital Bed Ad Hoc Committee officially, but I can give you my opinion.

MS. HAGENOW: That's what I'm asking. Because you've got background with it, why, in your opinion, was no requirement put in there?

MR. PARRISH: I think the assumption was that this kind of opportunity would primarily be used by ongoing hospitals who have a desire to increase the amount of service they can provide in a given area. The primary motivation, I think, behind this kind of thing would be that a hospital, as some of the other previous speakers mentioned, is experiencing capacity problems at that site; and this is a way to allow them to work out an arrangement with another hospital in the subarea that, perhaps, isn't as fully utilized to transfer some of those beds and capacities without having to go through the process of going through a comparative review and some of those kinds of things. So I think the assumption was that this would not be a primarily empty, unused hospital. It would be the recipient of a transfer like this, but it would be a hospital that was primarily on the other end of the continuum, one that was very fully utilized.

MS. HAGENOW: So it was solving a problem of under capacity, and putting a percentage of occupancy was irrelevant?

MR. PARRISH: I think it was -- the primary motivation, at least from our standpoint, is that if you have two facilities in the same subarea, which is a proxy for serving, generally speaking, the same population, and one is fully utilized and one has extra capacity, then it would seem to be a reasonable solution to both situations to allow capacity to be transferred from the underutilized facility to the more highly-utilized facility.

MS. HAGENOW: Thank you.

MS. TURNER-BAILEY: Commissioner Smant.

MR. SMANT: Isn't that also one of the differences, one is a subarea and the other is the health systems [service] area? Comparing what the previous speaker said, from a policy standpoint, if we do one, we have to

look at the other in the same policy mode. Are you then talking a difference of mileage here possibly? This language is a subarea; the other is health systems [service] area. Is that not a difference?

MR. PARRISH: I would say that is a substantive difference; yes.

MS. TURNER-BAILEY: Any other questions?

MR. GOLDMAN: I just have one.

MS. TURNER-BAILEY: Commissioner Goldman.

MR. GOLDMAN: This is Commissioner Goldman. I just have one comment in response to the last two speakers. Mr. Sahney asked what a hospital is, so Mr. Styka and I looked that up. And a hospital is a facility offering inpatient overnight care and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring daily supervision of a physician. So the language does say diagnosis and treatment. It would, therefore, not be a hospital just to have 50 beds somewhere.

MS. TURNER-BAILEY: Thank you. I have a card from Bob Davis. Was it your intent to speak on this issue?

MR. DAVIS: Pardon?

MS. TURNER-BAILEY: Was it your intent to speak on this issue?

MR. DAVIS: Transfer of beds in Oakland County.

MS. TURNER-BAILEY: Okay. That will be later. That's all the cards that I have on this issue. Is there any -- are there any more questions or discussions from the commissioners? Hearing none, a motion would be in order.

MR. GOLDMAN: This is Commissioner Goldman. I move approval of the language with the suggested technical amendments that are in our package and that Brenda just explained to us.

MR. BREON: Commissioner Breon supports.

MS. TURNER-BAILEY: Moved and supported.

MR. GOLDMAN: That would include all of our usual conditions. That would go into effect in the specified period of time.

MS. ROGERS: Move forward to the Legislature --

MS. TURNER-BAILEY: Move forward to the Legislature and waive the 135 days.

MR. GOLDMAN: So the motion is that we would approve the final language with the technical amendments, that we would send it to the governor, and that we would waive the 135 days.

MR. BREON: Still supported.

MS. TURNER-BAILEY: Ruled. Moved by Commissioner Goldman and supported by Commissioner Breon that we take final action on the language of the relocation of beds between hospitals within the same subarea with the suggested changes from the department moving forward to Legislature and the governor and waive the 135-day period. Any discussion? All those in favor, signify by saying. (Whereupon all affirm.)

MS. TURNER-BAILEY: Opposed? Motion carries. The next agenda item is with regards to cardiac catheterization services -- primary angioplasty without on-site surgical backup. Brenda.

MS. ROGERS: I'm going to have Dale Steiger from that ad hoc address the Commission. But before we do that, again, just to let you know, the department does have a minor amendment that is not included in the language you received. If you look at page two, section 2(1)(t), the definition of primary percutaneous coronary intervention, at the very end -- and this was approved by ad hoc; we just inadvertently left it out -- after the word elevation at the very end of the sentence --

MS. TURNER-BAILEY: Can you say where it is again?

MS. ROGERS: Okay. Sure. Page two, section 2(1)(t), line 98. At the very end after the word elevation should insert the words or new left bundle branch block. And, again, that was approved by the ad hoc. That was an oversight on our part. And, again, on page four, section 5, the heading of section 5, again, line 198, again, after the word elevation will be that same language inserted or new left bundle branch block. And, again, the department would offer that as an amendment if you move these standards forward. Thank you. I'll introduce Dale Steiger.

MS. TURNER-BAILEY: Mr. Steiger.

MR. STEIGER: Good morning. My name is Dale Steiger. I'm with the policy and program development group of Blue Cross and Blue Shield of Michigan. I was co-chair of the Cardiac [Catheterization] Ad Hoc Committee along with Dr. Joe Alberting, who is recently retired as vice president for medical affairs for the Kellogg Corporation. I'm not sure where Joe is this morning, but I'm hopefully going to fill in for him. I just want to say at the outset, I have -- the committees that I was associated with worked very hard on this. I had about two hours of prepared comments. And all of these people behind me I'm sure came to hear this discussion on angioplasty, but I would be very happy to dispense with the comments if we could get this approved quickly. I was also the chair of the informal technical work group of this committee that was established to try and come to some agreement on the primary issue before the ad hoc, and that is whether hospitals in Michigan should be permitted to perform primary percutaneous coronary intervention -- we're going to call that primary PCI -- for heart attack victims if the hospitals in question don't have on-site cardiac surgery backup or an approved CON angioplasty program. If so, if we want to move towards that type of service, under what conditions. The hospitals that were interested in this issue -- and they are a relatively few number around the state -- currently have active emergency departments that see a reasonable number of heart attack patients with the specific condition that can be helped by this procedure, and that's ST elevation. Don't ask any questions on that. I don't believe there's any clinicians in the audience. But these hospitals also have pretty active diagnostic heart cath programs, and they have access to cardiologists who can perform primary PCI on heart attack victims within the necessary time guidelines that have been established by the American College of Cardiology. These hospitals are also hopefully not in real close proximity of a hospital that currently provides angioplasty and open-heart surgery. But these hospitals that want to provide this service that we're talking about this morning do not have open-heart surgery programs, and they do not have angioplasty programs. The overriding issue before both the ad hoc committee and the technical advisory committee was will the residents of this state be better off if access to this procedure, primary PCI, is approved particularly in outlying areas even if the provider hospital does not have on-site open heart surgery backup. And our outcome is better for these patients if they have primary PCI rather than thrombolytic therapy, which is the standard of care currently in hospitals that don't provide primary PCI. Both committees decided that the answer to that is yes from both a technical advisory committee and the ad hoc committee. And I'm talking here about some of the state's leading interventional cardiologists that we were lucky to have on both of these committees. The residents will be better off and that under very tightly-controlled conditions, the benefits of having the procedures far outweigh the risks. The tightly controlled conditions that are laid out in your standards or provisions that the committee agreed on is section 5 of the proposed standards. To ensure that this procedure is available in hospitals that choose to provide the service, we want to make sure that this service is available 24 hours a day, 365 days a year. And it's not just an 8:00 to 5:00 service if someone wanders in the emergency room. These hospitals already have to be performing 400 diagnostic caths. They have to have a minimum of two experienced interventional cardiologists, both of whom have performed at least 75 angioplasty procedures for the last two years at a hospital with an approved angioplasty program. These physicians must be available to perform the procedure within 30 minutes of when the patient is identified as needing the procedure. The hospital must also be able to project 48 PCI procedures annually and must, after program approval, I think in the second year, Larry, must be providing 48 procedures a year. The hospital also needs a written agreement with an open-heart surgery hospital so that they have an appropriate transfer agreement.

Because the committee has felt strongly that minimum volumes, operator qualifications, and ongoing education work is extremely important components to show the success of those programs, these committees, the ad hoc committee and the technical advisory committee, went one step farther. They established an ongoing monitoring program, a daily registry, if you will, that will collect clinical information on each primary PCI patient that goes through this process at a hospital. The intent of which is to assist these hospitals and the physicians in achieving better outcomes for these procedures. This is not a new concept. Many hospitals doing angioplasty in Michigan belong to a private data registry, and other states such as New York and Maryland also have built this requirement into their state regulations which regulate primary PCI without surgical backup. But I think the data registry in terms of how it's described in your standards proposal is something new in the state. It's first for Certificate of Need in Michigan, and I think it's something that we can all be proud of. Everyone on our committee has supported this concept.

I think -- to close, I think the committee and the folks that have worked on this issue can serve as a poster child for Certificate of Need in the state. I want to also publicly commend the department, particularly Larry Horvath, for their excellent work on this issue. Without their help in contacting other states and contacting physicians from Johns Hopkins, we couldn't have moved forward as well as we did. So I'm going to urge the Commission to approve these standards since at the committee level, they had the unanimous approval of physicians, hospitals, and payers. I would be happy to answer any questions.

MS. TURNER-BAILEY: Any questions? Commissioner Sandler.

DR. SANDLER: I don't really have any questions on your standards. There's one point that this is really out of ignorance. I don't know. The CON is for emergent -- the new standard is for an emergent angioplasty following an MI of a heart attack?

MR. STEIGER: Right.

DR. SANDLER: What is the current CON requirements or what is the current policy for performing therapeutic angioplasty on a nonmyocardial infarct patient? In other words, you do a diagnostic cardiac cath for appropriate reasons. You see a blood vessel which could benefit from intervention, the same intervention if we had an MI. What are the standards for that? Do you need an open-heart program for that?

MR. STEIGER: Right. You need an open heart and you need an approved angioplasty CON, so you have to have both.

DR. SANDLER: And that's not being affected in this case?

MR. STEIGER: No.

DR. SANDLER: So you cannot do an elective angioplasty under your standards; you can only do an emergency angioplasty?

MR. STEIGER: Right.

DR. SANDLER: Did your committee look at the value of changing this -- and I don't have an opinion on this; it's really a question -- on elective angioplasty?

MR. STEIGER: No. It was never brought forward as an issue. And the issue that was brought to this committee was trying to help emergency MI's with ST elevation.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: Commissioner Hagenow.

MS. HAGENOW: I've heard this argument for many years. And what I'd like you to synopsize for me is what has changed that now makes it safe, because it's always been stated that it's turned down because it's not safe. What has significantly changed that's made it now safe?

MR. STEIGER: I think -- I can't answer that from a clinical standpoint, but the American College of Cardiology has come out with a number of studies the last two to three years. And the studies that they've done were in facilities that did not have open-heart surgery. And they have concluded through these studies that the risk involved in not having surgical backup was very, very low. I don't know what the percentage is of the patients that need open-heart surgery after an angioplasty, but it's very, very low. And the American College basically has come out and decided that the risk involved is worth it. And so we're basically piggybacking on that. One of the physicians on our committee was the Michigan president of the ACC. They are very supportive of this.

MS. HAGENOW: So, in essence, what you are saying is that the research now shows that the risk is outweighed by the benefits over longitudinal studies over a period of time?

MR. STEIGER: That certainly appears to be the case as long as these procedures are performed under the conditions that are described in these standards. We don't want somebody doing two or three a year. We want very experienced physicians involved. We want the hospital staff -- I didn't go through education and training for the rest of the staff, but there are requirements in there. And we think, the committee thinks, the physicians think that under very tightly controlled conditions, this is a reasonable risk to take.

MS. TURNER-BAILEY: Commissioner Breon.

MR. BREON: Just one question. Was there any criteria discussed for the open heart backup component like distance or --

MR. STEIGER: There is somewhere in the standards, and I don't recall what it is. I think the hospital has to be, what, an hour away. So yes; that is one of the standards.

MS. TURNER-BAILEY: Commissioner Goldman.

MR. GOLDMAN: I have a technical question. In section 5 where it says interventional cardiologists, at least two, to perform the primary PCI are experienced interventionalists who have performed at least 75 interventions annually, is that each who have performed 75?

MR. STEIGER: Yes.

MR. GOLDMAN: So would it be clearer if we inserted the word each? Because it says "who have performed 75", one way to read that is --

MR. STEIGER: I think it probably would be; yeah.

MR. GOLDMAN: So that would not -- that would be the intent of your committee?

MR. STEIGER: Yes.

MR. GOLDMAN: And then secondly, let me see if I can help Commissioner Hagenow. We had had some presentations including the presentation from an interventional cardiologist who had done one of the studies. My understanding was that this is a very narrow technical question. If there is an emergency and if you can get to the patient within the first two to three hours, then interventional angiography appears to have a better result in the sense of the artery remaining patent over thrombolytic therapy. That increase appears to go away if you can't do the interventional angiography within the first two to three hours, and then the patient's results appear to equal out. So that was the notion that drove the question of how can we get people into an interventional even though it might not have thoracic surgery backup. And that was a risk benefit analysis. And it was really that time difference that appeared to be important. In addition, what the studies appear to show is that if you are -- and this is no surprise -- if you are good at the technique and if your backup staff, nursing staff is good at the technique and good at recovery, the risk of perforation and of side effects appears to be low enough so that the benefit of immediate intervention outweighs that risk. And tell me if I'm not --

MR. STEIGER: That's essentially it.

MR. GOLDMAN: But that's what we had heard at public testimony before you commissioners came on the Commission. And that's what the studies appear to show. The ACC didn't make a recommendation strongly supporting this. They just said that there was new data and new evidence. And Harry Bates, who happens to work at the University of Michigan and who is the president of the Michigan College, believes that the evidence now as opposed to the evidence a few years ago is such that this is a reasonable step to take. So I think that's a fair statement.

MS. HAGENOW: Thank you.

MS. TURNER-BAILEY: Any further questions? Thank you very much. I do have one card. I might have one. I may have two. Jim Budzinski.

MR. BUDZINSKI: That's for surgical services later on.

MS. TURNER-BAILEY: Sorry. I have a card from Brennan Schwarz/Kheder & Associates. Would you like to speak or are you just letting us know?

UNIDENTIFIED SPEAKER: Just in support.

MS. TURNER-BAILEY: Okay. Thank you. There aren't any more cards for this. Are there any more questions or comments by the commissioners? Hearing none.

MR. MAITLAND: Maitland moves that we accept the proposed final action as presented with the staff recommendations of adding a new [left] bundle branch block in section 2(1)(t) and in section 5, who have each performed 75, along with the language as previously discussed concerning waivers.

MS. TURNER-BAILEY: It's been moved by Commissioner Maitland and supported by Commissioner Delaney. Any discussion? All those in favor signify by saying aye. (Whereupon all affirm.)

MS. TURNER-BAILEY: Opposed? Motion carries. Hospital beds -- Section 22209(3) of PA 368 of 1978, as amended. We have heard some discussion on this item already. I would like to take public comment under the conditions that I described earlier today. Again, please limit your comments to five minutes or less and representation to two per organization. Michael Webber.

MR. WEBBER: My name is Michael Webber. I'm representing Senator Nancy Cassis. And she circulated a letter last week to the senators. I would like to read it into the record. You all should have received copies on Friday either via fax or E-mail. Dear Commissioners: We the undersigned legislators urge you to support the ability of Detroit's three major health systems to relocate hospital beds between health facilities under certain circumstances as provided in the recently passed Certificate of Need reformed legislation, PA 619 of 2002. Last year the Legislature voted intentionally on a bipartisan basis to include the language allowing the bed transfer and intentionally created a rigorous standard that would need to be met in order for this provision to be challenged by the CON Commission. Allowing for the relocation of hospital beds will strengthen the Detroit health systems and assist them in offsetting some of the extraordinary losses incurred by hospitals located in the city. An additional reason the Legislature agreed to allow for the transfer of hospital beds under certain circumstances as stipulated in the legislation was in recognition that existing bed need standards do not accommodate significant shifts in population that have occurred since the bed need standards were last revised more than a decade ago. The current standards have resulted in a misdistribution of hospital beds resulting in a surplus of beds in areas with declining demand for inpatient beds and a deficit of hospital beds in geographic areas with a growing population and need for additional services. We urge you to support the ability of the Detroit-based health systems to relocate hospital beds under the bed relocation language included in PA 619 of 2002. And it was signed by -- it was signed on a bipartisan basis by Senators Nancy Cassis, Tom George, Laura Toy, Ron Jelinek, Jud Gilbert, Jason Allen, Bruce Patterson, Patricia Birkholz, Michelle McManus, Wayne Kulpers, Mike Goschka, Michael Switalski, Buzz Thomas, Michael Bishop, and Beverly Hammerstrom.

MS. TURNER-BAILEY: Are there any questions?

MR. WEBBER: I can give extra copies.

MS. TURNER-BAILEY: Thank you. Joann Watson.

MS. WATSON: Good morning. My name is Joann Watson. I'm a City councilwoman from the city of Detroit and have been working with the coalition for healthcare equity for five years, a coalition that has been monitoring healthcare delivery, healthcare services for citizens in the city of Detroit. We believe, against the backdrop of the specific challenges at the city of Detroit at this time with the proposed closing of Receiving Hospital, rendering services at Hutzel Hospital, all of the other hospitals that have been closed inside the city of Detroit with a majority of the residents residing in the state of Michigan, that expanding beyond Detroit city limits in an area -- Oakland County, for example, has a 50-percent bed occupancy currently. We believe that the arguments that having more hospitals operating in suburban locations surrounding Detroit would better subsidize the cost of uncompensated care in Detroit cannot be substantiated by the current policies and practices. We believe that it imposes a threat to the quality of healthcare services, which are already very limited and posing a great danger for citizens in the city who are dependent upon Detroit-based healthcare. We currently already have more than 40 percent of persons who have Medicare going outside the city. Persons who have other insurance, 40 percent of those are already seeking services outside the city of Detroit. Those persons who can go anywhere, more than 40 percent of them are already traveling outside the city of Detroit. It is a major challenge to the healthcare coverage of the citizens who cannot travel outside the city. Those whose circumstances will not allow them to be served outside the city poses a very clear and present danger to the healthcare quality of the city of Detroit and also those persons who work in Detroit and don't live in Detroit. Detroit has just under a million residents, but there are two million who are in Detroit on a day-to-day basis, who work in Detroit Monday through Friday. That two-million population, which includes residents in the Pointes, those persons, if they have need of serious services like level-one trauma -- level-one trauma services are tied in with Receiving Hospital, the only level-one trauma site inside of Wayne County. Everyone would suffer if this situation is not addressed. We believe that approving the CONs outside the city of Detroit for hospitals who are now primarily housing the city of Detroit would pose even a more significant challenge to the citizens of Detroit and citizens who work in Detroit. All of the evidence, all of the evidence, all of the data points to the need to increase services inside the city and not to decrease, not to maximize. There's a 50-percent vacancy, once again, already in the area where the proposed expansion would take place. I thank you very much.

MS. TURNER-BAILEY: Thank you. Can you wait one moment to see if they have questions, please?

MS. WATSON: Yes, ma'am.

MS. TURNER-BAILEY: Are there any questions?

MR. MAITLAND: Maitland. I appreciate your coming to speak. And did you have an opportunity last fall to speak to the Legislature about your concerns on this issue when they were working on this law?

MS. WATSON: As a matter of fact, I spoke with almost all of them as a person who -- I did not speak as a City councilwoman at that point. I'm the new City councilwoman. I am not new to healthcare. I'm the only woman that's ever been a director of the NACP in Detroit, which is a flagship branch of the country, and a long-time executive director of the YWCA, an agency long engaged with all of the family-strengthening resources that are necessary. We believe that the healthcare delivery in Detroit is not just a new issue. It's not a new danger, but it's one that's become an acute care issue for the city of Detroit, which makes it an acute care issue for the state of Michigan. You cannot have all the things that are now posing challenges to healthcare in Detroit without having the whole state impacted. The proposed reduction, closing of services at Hutzel, which is the most significant facility serving high-risk perinatal, neonatal births; and Receiving Hospital, the only level-one trauma center in Wayne County. Without a level-one trauma center, you can't host a Super Bowl. Detroit cannot have a visit from the president of the United States without a level-one trauma center. And it's just not something that poses a challenge to Detroiters. It's a challenge for the entire state. And I urge that you look very close at the needs of Detroiters who would be not served well by CONs granted for expansion as it's been proposed.

MR. SMANT: Jack Smant. Do you have any comment you would like to make on the letter that we received from the mayor of Detroit?

MS. WATSON: The mayor is a wonderful person. I'm one of the four women, other than his own mother, he calls mama. In fact, Mr. Mayor Kwame M. Kilpatrick will be having a meeting with Mama Watson on Thursday at 3 o'clock. We do not agree on this issue. Thank you.

MS. TURNER-BAILEY: Any further questions? Thank you. David Parr.

MR. PARR: Good morning. My name is David Parr. I come before you on this subject as a private citizen, small business owner, and must tell you that I'm also chairman of the board of St. Mary Mercy Hospital in Livonia. As a small business owner, private citizen, I'm very concerned about the costs that we're adding in here. As I understand it, up to $600 million will be added into the cost of doing business. That money doesn't fall out of trees. It's paid in terms of premium dollars, and it's paid by primarily private business. And it's not just small businesses concerned here. Ford Motor Company, GM are all concerned about the cost of providing adequate health insurance coverage for their employees. What's really happening here? We're about to add $600 million into this region in costs that we haven't had right now to serve people that are already adequately served, to serve an area that already has excess capacity, and yet we haven't even begun to address the real problem that everybody's talking about, and that's the problem of the uninsured and underinsured. I'm concerned. I'm concerned about how we continue to stretch this out. My comrades in small business, their solution is unfortunately to drop the insurance program. They're actually calling their employees in and saying we're going to give you a 25-percent raise but no more health insurance. We've got to cut it out because it's an uncontrollable, at-risk, high-level, out-of-control cost. And they can no longer afford it. More uninsured people enter the ranks. More pressure on those people that are insured, more pressure on that premium. We can't afford to continue to do this. If there was a need, I'd be the first one to be stepping forward and saying let's do something about this need, but there isn't. At our hospital, we have a 40-percent vacancy rate. We can still accommodate an awful lot of people, and we serve southern Oakland County. Other neighboring hospitals that will be close to the sites that they're talking about also have excess capacity. So I would encourage you and urge you to consider the additional costs that we're adding into the system that do not need to be added in. We need to look for ways to keep these costs down so we keep insurance affordable, so we keep more and more people insured and not present a case where it's a certainty that more people will become uninsured. Thank you for your time.

MS. TURNER-BAILEY: Are there any questions? Thank you. Deborah VandenBrook.

MS. VANDENBROOK: Chairperson Turner-Bailey and Members of the Commission, I would like to thank you for the opportunity to appear before you today. I'm Deborah VandenBrook, president and CEO of St. Joseph Mercy - Oakland, which is located in Pontiac, Michigan. I'm pleased that you are providing the opportunity to hear multiple views about the proposed two new suburban Oakland County hospitals as part of your deliberation. The proposed new Henry Ford Health System hospital in West Bloomfield would be located about 11 miles and approximately an 18-minute drive from St. Joseph Mercy - Oakland. The Providence - Novi Hospital would be located another eight miles and an additional 14- to 15-minute drive from St. Joseph Mercy - Oakland. The service area of these two hospitals and St. Joseph Mercy - Oakland would overlap considerably. We are a full-service hospital that provides a continuum of hospital services from primary care and other ambulatory services to open heart, neurosurgery and other tertiary services. The top three services of our hospital include cardiology, obstetrics, and pulmonary medicine. Additionally, we welcome about 2,500 newborns a year. Our roots are in Pontiac. We are located on the Woodward corridor. And our mission and service area extends and has been expanding throughout Oakland County including the geographic area located around where the new Henry Ford - West Bloomfield Hospital would be located. Currently St. Joseph Mercy - Oakland's occupancy rate of licensed beds is about 69 percent. As such, we are able to absorb additional patients and provide more services without significant incremental costs entailed by the construction and staffing of a new hospital, which has been presented already, would add significant fixed costs to the healthcare delivery system, which is already too costly for many people and businesses to afford. We are looking to the future in order to meet the needs of Oakland County residents for high quality of care. As such, St. Joseph Mercy - Oakland, pursuant to a Certificate of Need is making extensive investments to create an emergency center in order to have a capacity to meet a growing demand for emergency services up to 65,000 emergency patients per year, upgrading 90 of our patient rooms to meet contemporary requirements for the

recuperative period of our inpatients and reconfiguring our imaging center as to allow quick access to patients with immediate requirements for imaging and other imaging services among other changes in this project. Each of these investments and all of the services we offer are implemented with a view toward better serving Oakland County residents as well as achieving physical balance while being a safety net hospital. The safety net hospital meets the needs of low-income uninsured individuals as well as absorbing significant Medicaid payment losses. Unless our margins on our insured patients are reasonable, we are limited in our ability to effectively participate in community wide initiatives and improve and maintain the health status of Pontiac and Oakland County residents. And I can assure you that the health indices in the city of Pontiac are very challenging and worrisome. People think of Oakland County as wealthy. It is. Per capita income in 2000 was estimated to be $50,000. By some account, per capita income is among the ten highest nationally. Household income in Pontiac, however, is about $30,000 in 1990. Additionally, there are about 120,000 uninsured individuals in the county, many of whom reside in the Pontiac area. It is these individuals for whom St. Joseph Mercy - Oakland is a safety net. Let me give you a run-down of some of our services to meet the safety net needs of our community and the dimension of our services. We have Mercy Place, our in-the-community free clinic which serves many low -- employed low-income individuals at about 4,000 visits a year and growing. Additionally, we have a partnership in the Pontiac schools to provide school-based health services at the elementary level in a high-risk school district. We actually employ two of the school nurses and work with the school district to help improve healthcare outcomes. We partner with North Oakland Medical Centers and Pontiac Osteopathic Hospital Medical Center as well as with the mayor's office to reduce infant mortality. We play a large part and an important role in Healthy Start of Oakland County, a program that targets infants and toddlers, newborns to age three and their families who are at high risk for health problems, abuse, and neglect. This program and the cost of other programs for low-income residents totaled about $8 million last year. Our indigent pharmacy program has spent, at no cost to the recipients, about $1 million in pharmaceuticals to low-income individuals without any prescription drug coverage. The hospital provided about $1.2 million in charity care to low-income, uninsured individuals. And we wrote off approximately $3 million in Medicaid payments and losses. Our benefit to the community measured a cost total of about $13.2 million last year. We are proud of this commitment to Oakland County. We want to continue and expand upon it. The need is definitely there. However, it will be impossible if this Commission permits the building of two Oakland County hospitals, draining of many of our insured patients that come from outside Pontiac. We expect that these patients would seek services at the new hospital at the expense of St. Joe Mercy - Oakland. We see negative impacts on access costs and quality of care and services in Oakland County, the three balancing prongs of the Certificate of Need Statute. Specifically we believe that permitting a priority and without deliberate consideration through bed need methodology analysis, the deployment of two new hospitals will result in, quote, "great harm and detriment to the access and delivery of healthcare to the public." As such, we do not believe that the relocation of beds should occur without a Certificate of Need. Let me provide my rationale. Access, the $3.2 million in community benefit provided annually by St. Joe's could be defined as the creation of access for individuals that otherwise would not be able to receive the needed healthcare services. To the degree that our payer mix tilts away from patients who have third-party coverage, that underwriting costs that these services provided, our ability to maintain our access-increasing programs will diminish. Like all other hospitals, we incur fixed costs when we believe that they can be reasonably amortized over a reasonable period. Should our patient volume diminish below our expectations, our efficiency will decrease and our cost will decrease. From a quality perspective, the Certificate of Need standard currently incorporates volume as a predictor of quality, a future which we wish we were in agreement. To the extent that a given volume of service needs are scattered across a set of providers rather than a concentrated and center of excellence, we believe that quality will be diminished. I trust that you will give my views consideration as you work through your decision. I also have with me letters from Pontiac community leaders who are also concerned about this initiative. That includes the mayor of the city of Pontiac, Mayor Willie Payne; Pontiac city council members; the NAAC North Oakland vice president, Harrison Munson, Esquire; the Oakland Lighthouse Executive, Norene Keeding. I request that these be incorporated into the record as well. Thank you for the opportunity to provide input today.

MS. TURNER-BAILEY: Thank you. Are there any questions?

MR. MAITLAND: Maitland. Your comments concern mainly subparagraph B. Do you have any thoughts on C, which allows relocation of beds within the health service areas? Do you have any thoughts on that or the impact that has?

MS. VANDENBROOK: We're supportive of that. I'm not exactly sure what you're getting at.

MR. MAITLAND: I just wondered if you had any thoughts on that. I mean, that allows, my understanding, the moving of quite a few hospital beds within health service areas unrestricted.

MS. VANDENBROOK: That's within health service areas.

MR. MAITLAND: Which are quite large, aren't they? You don't -- okay. Thank you.

MS. TURNER-BAILEY: Thank you. James Cavanaugh.

MR. CAVANAUGH: Thank you, Madam Chair and Commissioners, for the opportunity to address this Commission once again. My name is James Cavanaugh, an attorney with the law firm of Kelley Cawthorne here in Lansing. And our firm is headed by our former attorney general, Frank J. Kelley. We represent St. John Healthcare System. Mr. Kelley was unavoidably called upon for another appointment out of town today, but he has asked me to read his testimony to you today. Two weeks ago, the office of attorney general advised this Commission that Article 5, Section 6 of the State Constitution prevented the Commission from taking a vote as to whether to reject the legislatively mandated bed transfer plan. I testified in support of the attorney general and the advice given this Commission. And I urge the Commission to follow that counsel. Subsection 9 of the operative statute confers upon this Commission the power to reject -- the power to reject the legislatively mandated plan unless seven or more members of the Commission, after the appointment and confirmation of the six additional Commission members under section 22211 but before June 15, 2003, determine that relocation of licensed beds may cause great harm and detriment to access and delivery of healthcare. The key words in the statute are seven or more and the appointment and confirmation of the State's additional Commission members but before June 15, 2003. It is a fundamental rule of statutory construction, that the plain meaning of the statutory language must be given its intended effect. It is clear that if there is a vote to reject the legislative plan, it must be by a super majority of seven members but only -- but only after the appointment and confirmation of the six additional members. While the appointments of the six members have been made, the confirmation of all six have not occurred and will not occur prior to June 15. Thus, it is impossible for the Commission to fulfill this mandate of the statute, and the legislative plan must go into effect. In short, the Commission has not been statutorily perfected to take any action in this regard. Article 5, Section 6 of the State Constitution makes it clear that appointment by and with the advice and consent of the Senate means appointment subject to disapproval, not approval, by a majority vote of the members elected to and serving in the Senate. Furthermore, the Constitution specifies that the Senate must act to reject an appointment within 60 days and that any appointment not disapproved within such period shall stand as confirmed. As attorney general, I opined on several occasions that the power of advice and consent amounted to the power to reject a governor's appointment and not to affirmatively confirm. And whether the Senate acts affirmatively or not, confirmation takes place only after the expiration of 60 days from the date of appointment. I am mindful of the fact that an OAG number 6120, 1983, 1984, there is a statement at the very end of my opinion which says that the Senate has an affirmative power to consent to an appointment. That statement is incorrect and completely conflicts with the previous six pages of that opinion and of other opinions of mine which stand for the proposition that the Senate only has the power to reject an appointment and not to confirm one. I urge you to take the concerned advice of your legal counsel, the attorney general, and the precedent set on this matter dating back nearly 40 years and developed by attorneys general of both political parties. I urge you not to take a vote on this matter. Thank you very much.

MS. TURNER-BAILEY: Any questions? Thank you. I'm going to try and -- I wasn't exactly sure what you were going to say. But try to keep all the legal discussions together when we get to discussion, please. So if you want to give legal advice, let me know when you get up there, and I'll put those together. Mark Tendrusky.

MR. TENDRUSKY: Good morning. I'm Mark Tendrusky, director of immigrated healthcare and disability at the Daimler Chrysler Corporation. I appreciate the opportunity to share with you Daimler Chrysler Corporation's thoughts and concerns surrounding the legislation enacted in December. More specifically, it's a potential impact on the cost, quality and delivery of healthcare in our home county of Oakland. We contend that the addition of unneeded beds in Oakland County as tentatively permitted under subsection 22209 sub (3) of the December legislation would result in severe damage to the access and delivery of healthcare in southeast Michigan. We therefore ask that the Commission exercise a right under subsection 22209 sub (3)

to disallow the proposed construction of new hospital beds in Oakland County. We at Daimler Chrysler appreciate the financial straights and strain being placed on the Detroit-based healthcare systems, DMC, St. John's, Henry Ford Health System by the number of uninsured, the high number of uninsured and underinsured patients they serve. Henry Ford and St. John's proposed establishment of new or expanded facilities in Oakland County, however, is definitely the wrong solution to a serious problem. Oakland County, with the exception of Beaumont Hospital is already heavily overbedded. Exporting Henry Ford and St. John's beds to an overcrowded market and adding additional beds to DMC's Sinai Huron Valley facility will increase cost pressures on existing hospitals, make them less efficient and will likely drive up unjustified and sometimes dangerous utilization of hospital facilities in Oakland County. As an individual, I'm opposed to the proposed bed additions, even though I might seem on the surface to personally benefit from the move. I've been a resident of Lake Orion and West Bloomfield for the past 13 years, communities in the backyards of where the proposed expansions would occur. I feel that I have an excellent choice in nearby hospital facilities without the need of additional locations. Availability of healthcare resources has been proven to drive utilization. Money spent on capital expansion must be recoverable. This drives up cost in the end. It's the companies that provide comprehensive health insurance that will pay the price. Ford, General Motors, Daimler Chrysler are operating on razor-thin margins. There have been many dire projections about the future of GM, Ford, Daimler Chrysler. In fact, one recent prediction is that GM and Ford will be bankrupt, out of business within the next ten years. Failure of any of the three autos would have dire consequences for Michigan. Presentations at the recent Detroit Regional Chamber of Leadership conference at Mackinac Island attributed six percent of the jobs and eight percent of the personal income in Michigan coming from the auto industry. Healthcare is one of our greatest supplier costs. When you buy a Dodge Neon, $1,300 of the cost is healthcare. Healthcare is one of our -- it's a tremendous cost. It's raging out of control, and we need to use every means at our disposal to insure that it does not lead to our demise. Adding unnecessary hospital construction overhead costs in the Oakland County healthcare system is a luxury that we can't afford. Cost is a direct impact on both access to care and delivery of care in Oakland County and southeast Michigan. Losses incurred by the existing Oakland County hospitals may force them to abandon many programs and services and impact the efficiencies of the programs that remain. As costs to employers' rise, many will further cut back both the scope of benefits provided and the choice of providers offered. Smaller employers may be forced to stop providing healthcare altogether. It's probably no secret that the whole area of healthcare is going to be a major issue in the upcoming three-company UAW negotiations, and benefit reductions are possible. It is also worth noting that as the level of medical coverage declines and as employee cost sharing increases, some employees may delay or forego medical care because of financial concerns. Clearly, construction of new facilities in Oakland County would pose an imminent and substantial threat to access and delivery of healthcare.

The debate over the Oakland County migration issue also has an important quality issue attached to it. As many of you know, there's a serious nursing shortage. Whenever new facilities are built, it's going to exacerbate the nursing shortage. Furthermore, bidding is going to break out with respect to hospital personnel of all types and especially for those specialties that are in short supply. This is likely to increase salary levels and drive up overall costs of medical care in the area. Hospitals that operate without a sufficient number of skilled personnel represent both an access and delivery problem, potentially placing its patients at substantial risk. Studies indicate that the proposed new Oakland County facilities will do little to improve the overall financial position of the Detroit-based hospitals while generating major negative cost implications for Oakland County healthcare and the companies that support it. Trinity Health estimates that the proposed new Henry Ford and St. John's facility would generate an estimated annual profit of about $10 million causing a yearly drop in profit base to existing hospitals of about $68 million. Obviously this is far from the zero sum gain. When you factor in the resulting major harm and disruption for health access and delivery that would be caused by the new bed construction, it is clear that such expansions should not be allowed to proceed. We respectfully ask that you exercise your prerogative under subsection 9 by preventing the construction of the additional unneeded hospital beds in Oakland County. Thank you.

MS. TURNER-BAILEY: Are there any questions? Thank you. Maryann Mahaffey.

MS. MAHAFFEY: Thank you very much for having this public hearing to give an opportunity to people to speak to this issue. I am Maryann Mahaffey, president of the Detroit City Council. I've been on the council since '74. I have been on the Michigan State Health Coordinating Council back when we were debating Certificates of Need. I have been chair of the National League of Cities Policy Committee on healthcare back

in the '80s when we were concerned about then 30 million uninsured and we were concerned about the fact that we had so many healthcare systems depending on your income, your physical condition, et cetera. And we came up at that time with a policy for the National League of Cities that still exists, namely, we need one healthcare system. I give that as background. My first term, Crittenton Hospital left Detroit. They took jobs, they took patients and patient care because they provided a certain service. My concern and our concern is that more beds outside Detroit inevitably means that people leave, that jobs leave, and that it does not help our economy at all. I have with me a study done by the Market Strategies Healthcare Research & Consulting, Inc., in collaboration with Community Health Institutes of Wayne State University and the Detroit Medical Center. And in that report, they point out that 42 percent of Detroit residents with Medicare travel outside Detroit for healthcare. Forty-two percent of Detroit residents with commercial insurance travel outside of Detroit for healthcare. And I would maintain that our city, as a result of all of these changes, Crittenton leaving -- and that was only the beginning -- that we do not have the basic healthcare resources to care for our population, and to have more developed out of the city only will exacerbate the problem. For example, right now, we have, yes, the number of indigent in Detroit has increased but not that much. What's happened is the percentage of the total healthcare potential population has zoomed because so many with commercial insurance, for example, have left Detroit and the Detroit system. The total number coming through has been reduced so the percentage of indigents increase. I want to say also, incidentally, that when people talk about the problems in Detroit, they keep talking about indigent care. One of the problems, also, is that some of -- that uncompensated care means that some commercials don't pay on time; and, therefore, for the institution, it gets figured as uncompensated care and too many people turn it into indigent. I'm an example. I had to be hospitalized about a year ago. This is one that still grinds me. And the bills weren't paid even though I told my HMO. And finally I began to get collection calls. And because I was fortunate enough to have a title, I sat next to someone from my HMO with a title and complained about them not paying the bill. And I knew I was being registered in the other hospital outstate as uncompensated care. They said they'd take care of it, and I got a nice picture frame. But then I got a nasty call from a collection agency. So I called the VP, and it did get taken care of. The reason I throw that in is that as we talk about urban centers, there's not only the question of indigent care, there's the question of uncompensated care; and there's the question of how much is available to people within the urban center and how many times are we forced to go outside. And we have no mass transportation. One-third of the people in Detroit do not have cars. Another third, their cars wouldn't go very far. They may be good enough to get you to a job, but one of our problems is that the jobs are way out, and people don't have the transportation to get to them. So when you talk about more beds in Oakland County and wherever, then the question is what happens to the existing beds and where does that leave us in terms of care for the people who live in Detroit. And I want to also point out that I've heard all the arguments, but I would point out that the hospitals have to have more beds outside because, otherwise, financially, they can't make it. And underneath it sometimes is a whisper of racism. Cleveland Clinic is in the heart of a very poor minority community but has a worldwide patient list. Henry Ford has a very broad patient list, and Receiving Hospital as a trauma level-one hospital in Wayne County has a national reputation as does Wayne State Medical School. And we need all of them. We don't need threats to their existence by moving out and providing an opportunity for people to reduce their beds in Detroit because they say they don't get enough money and open up outside and then that has a further impact on those -- I mean, if you can go outside or you're urged to go outside, then, you know, you reduce the patient list in Detroit, you reduce the reimbursements for services in Detroit. And the end result is that Detroit and the urban centers lose. And this is a problem nationally. I'm active in the National League of Cities on their National Policy Committee. And this is a problem all over, an eagerness to move out and to say, you know, people won't come in. But if they'll come into the Cleveland Clinic, why won't they come into Detroit? But if we offered more beds outside, then why do you have to go anywhere but to the hospital next door when we have a fabulous hospital in Receiving with its level-one trauma center and with better operating rooms, for example, than others in the immediate vicinity. And so for us -- and I'm speaking from the history of the Detroit City Council of our position through the years. For us, we don't see more beds in the suburbs. We see the necessity of maintaining what we have and getting people to understand that we have wonderful services, and the answer isn't going to be to move out. The answer is to stay and recruit people to come in. Thank you very much for this opportunity to speak.

MS. TURNER-BAILEY: Any questions? Commissioner Hagenow.

MS. HAGENOW: Would you comment on the fact that the people that have moved out are not the systems that are asking to add to and stay in.

MS. MAHAFFEY: Well, one of the systems that's asking to move out already spent some of our Receiving Hospital reserves to buy hospitals out. So I don't think that's the answer.

MS. HAGENOW: I'm speaking of the Ford system has never indicated moving out. It's saying we're staying but adding to -- the St. John system is saying they're going to add to but stay. And the ones that have left have left. And that's not the ones that we're talking about in this particular issue.

MS. MAHAFFEY: I apologize for starting to interrupt you. I hate it when people do it to me.

MS. HAGENOW: That's okay. I wasn't speaking of DMC. I'm speaking of the two particular systems that are impacted have never indicated, as I understand it, inclination to leave.

MS. MAHAFFEY: Well, but in the beginning, they weren't going to leave. But now they've built in the suburbs clinics and now they want to expand them. And as I understand it, they already have enough beds in Oakland County to take care of the need. In my experience, it isn't just Crittenton Hospital. It's once you build the beds outside, then more and more get pushed to go outside. I had minor surgery at the West Bloomfield Ford Clinic. And if they add more beds, it's likely that they'll do more out there. And it's just like an inevitable piece of -- I don't know if gravity is the right expression to use. I hate to be wrong in my choice of words.

MS. HAGENOW: Thank you.

MS. MAHAFFEY: Thank you.

MS. TURNER-BAILEY: Are there any other questions? Commissioner Sandler.

DR. SANDLER: Do you recall me from the dinner we had a couple weeks ago?

MS. MAHAFFEY: Yes. Yes. The Medical Society. Thank you. Wayne County Medical Society.

DR. SANDLER: That was delightful having dinner with you, and I enjoy hearing your testimony. As you told me then, you were a Henry Ford patient and you mentioned you -- I wanted to commend you on your choice of hospitals.

MS. MAHAFFEY: Commend me on what?

DR. SANDLER: On your choice of hospitals.

MS. MAHAFFEY: Oh, thank you.

DR. SANDLER: That was excellent judgment.

MS. MAHAFFEY: Well, you've got good doctors, and we have good doctors at the university clinics. And we need to keep all of them.

DR. SANDLER: Thank you for your thoughts.

MS. MAHAFFEY: Thank you.

MS. TURNER-BAILEY: Are there any other questions? Thank you.

MS. MAHAFFEY: Thank you.

MS. TURNER-BAILEY: Martin Johnson.

MR. JOHNSON: Good morning. My name is Martin Johnson. I live on Michigan's west coast in Grand Haven. I'm chairman of a privately-owned manufacturing company founded in 1970, JSJ Corporation. It has been headquartered in Grand Haven for 33 years. Primarily the same three families have owned JSJ and its

predecessor company since 1919. We are a diversified manufacturer with about 1,900 employees, half of whom live in Michigan. None of our facilities are located in southeastern Michigan. I am presenting testimony for the Economic Alliance for Michigan to emphasize that the Alliance is a statewide organization of businesses and unions from all over the state, and our members are from a wide range of economic sector, not just automotive. Many of our members are concerned about what happens in southeastern Michigan because it can and will impact those of us in the rest of the state. Of course, we are also concerned with provisions of the legislation that has direct impact on those living in southeastern Michigan. I have been involved with healthcare for much of my business life. That has included service as a trustee of our local hospital, North Ottawa Community Hospital, for eight years from its founding until 1975. Of course, as an officer of JSJ for more than 30 years, 23 as its chief executive officer, affordable healthcare has been a major concern. As a conservative republican, I am opposed to many proposed government regulations directed at competitive private businesses where the buyer pays the bill and is free to choose among many suppliers. Healthcare is different because the recipient or the service seldom directly pays for the services render. The Certificate of Need process is appropriate and needed because there is almost total disconnect between the patient caregiver relationship and the payment mechanism. About 90 percent of hospital inpatient fees are paid either by government from taxes or subsidized by the taxpayers. Given the limited time, I will skip much of my prepared testimony to focus on the nonsoutheastern Michigan ramifications of subsection 22209(3) dash C, which I call 3(c). 3(c) has major impacts far beyond the hospitals located in Detroit. 3(c) would allow the relocation of 10,000 beds in great many hospitals located throughout the state. That relocation would extend to anywhere within the eight large health service areas in which a system -- a major system owns multi-hospitals, excluding the hospitals in the same subareas for which CON Hospital Ad Hoc Committee recommend easy relocation. Moving beds all over the state has nothing to do with indigent care and uninsured problems in Detroit or anywhere else. All it does is eliminate the constraints of the CON community need-based criteria from the issue of which hospitals are able to expand. This legislation is only applicable to system-owned hospitals being able to expand. It does not include independent hospitals. Moving beds for indigent care goes counter to the intent of the CON law and I would think by anyone in the Legislature last December. Let me give you some examples of what would be allowed if the Commission does not block the implementation of 3(c) today. In my own area, Spectrum Health, a dominant system in western Michigan, could transfer beds from their Grand Rapids hospitals to Muskegon or Reed City hospitals. In southeastern Michigan, Ascension could transfer 35 percent of its beds from St. John Hospital in Detroit to Brighton Hospital in Livingston County or to its River District in North Shores hospitals in Macomb County. There are many similar examples throughout almost every other HSA in the state. By the way, the further impact of 3(c) related to freestanding surgical centers would allow St. Mary's - Saginaw and St. Joseph - Tawas, both owned by Ascension, which owns St. John, which owns Providence, to transfer 35 percent of their beds to a freestanding outpatient facility in southern Saginaw County. Such action would automatically create yet another hospital in that county. These examples and many others could occur without benefit of CON determination of community need. At a time when Michigan's licensed hospital beds are running at about 15-percent occupancy, we think there is a great and continuing value for the CON process. Purchasers and consumers need that review process to determine when and if new hospitals should be initiated and current hospitals should be expanded. And those determinations should be based on the overall need of the local communities, such as we're hearing this morning, to be served and not on the particular interests of the sponsoring health systems. Over the years, the Economic Alliance for Michigan has strongly supported the CON program, and we continue to do so. We believe that CON has prevented duplication of unneeded services and facilities. Thank you for allowing me to speak to this issue.

MS. TURNER-BAILEY: Thank you. Are there any questions?

MR. MAITLAND: I just thank you for bringing up 3(c) because I've been concerned about that, and we've had very little discussion. I appreciate it. And anyone else who might want to speak about 3(c), I would appreciate it.

MS. TURNER-BAILEY: Thank you. As we approach the noon hour, we're going to take a lunch break. I want to announce that lunch will be provided in the Michigan room for guests. Kheder & Associates can be thanked for that. And the commissioners' lunch is ready in the Superior Room. (Whereupon a lunch recess was taken.)

MS. TURNER-BAILEY: I'm calling the June 10th meeting of Certificate of Need Commission back to order. We're going to resume hearing public comment on agenda item seven, hospital beds -- Section 22209 sub (3). I'm going to repeat my request that you limit your comments to under five minutes and, again, that no more than two people per organization speak. And I guess, to be frank, if there's two of you speaking, if you're not saying anything different, then I will ask you to refrain from repeating any comments. We did have an entire day of testimony on this issue just less than two weeks ago. So I think we can use our best judgment, I guess is what I'm asking you to do. We are going to get to a point probably around 2:15 or so where we are going to cut off public testimony in the interest of time and the interest of trying to get through the agenda to the best of our abilities. So to start this afternoon's comments, I call Michael Slubowski.

MR. SLUBOWSKI: Chairperson Turner-Bailey and Members of the CON Commission, I thank you for this opportunity to appear before you once again. My name is Michael Slubowski. I'm executive vice president of Trinity Health. Page one of our briefing summary, which is being handed out to you today, will remind you of our testimony on May 28th, which I will not repeat. In summary, we stated that building new suburban hospitals will not solve the Detroit hospitals' financial crisis. The facts that we presented, which are also on pages two and three of our briefing summary, demonstrate that these new hospitals will generate insubstantial income and will not provide a return on investment to offset uncompensated care losses. Building new hospitals will weaken many existing suburban hospitals including safety net hospitals in Pontiac. The provision of 619 which bypasses CON for construction of new suburban hospitals will cause great harm and detriment to the access and delivery of healthcare to the public, and relocation of beds should not occur without a Certificate of Need. We recommend that the highest priority for the Commission should be to update the bed need methodology to reflect changes in population and age, utilization rates, drive times and other important factors. At the last meeting, draft language was introduced by MDCH as proposed modifications of the CON standards. This draft language literally lifts special exception language for new hospitals for three Detroit providers from PA 619 and inserts it into the CON standards. Rather than updating the bed need methodology and having hospitals follow the CON application process for beds, it literally gives a "no bid" contract to three providers without the accountability that CON was designed to accomplish for the public good. We cannot support these proposed changes to the CON standards. I would like to address some of the unresolved issues that were raised during our last meeting on this subject. First, there's much confusion over the number of beds that can be moved to Oakland County. The language in PA 619 is very ambiguous. Every person who reads the language on bed relocation comes up with a different interpretation. We believe that the language allows for 35 percent of the licensed capacity of DMC, St. John, and Henry Ford to move, as indicated on page four of our briefing summary. Depending on interpretation, the one-time move per hospital language is also ambiguous and may apply to each hospital currently owned by the system. Certainly we know from testimony that at least one applicant is planning to move beds from at least two hospitals. In short, the ambiguous language could allow for the three health systems to relocate almost 2,000 beds and not necessarily at one time. The ambiguous language could also apply to bed relocation in other parts of Michigan. The assessment of great harm and detriment is dependent on clarifying the absolute number of beds that can be moved against the bed need and impact on current providers. Next, there was a suggestion that suburban providers who say there's no need for more beds are really just using this as a guise for the fact that they don't want the competition. In fact, it was pointed out that, from review of actual statistics, the growth and population and changes in use rates do not appear to be substantial enough to make the case that these new hospitals can succeed without taking business from other providers. Furthermore, the drop in volume and income at existing hospitals will put their charitable missions at risk. It's ironic that the organizations who are accusing existing suburban providers of not wanting competition are, in fact, seeking to avoid competition by bypassing CON and seeking an automatic franchise in western Oakland County. It's, in fact, these organizations that do not want to compete on the merits of their proposals after going through a comparative review process. If a revised bed need calculation indicates a need for beds in western Oakland County, then hospitals should apply for a CON and compete to provide those beds on the merits of their applications as they address the improvement of cost, quality, and access. One of the arguments made during testimony last time was that the profitability for the proposed suburban hospitals will be higher than state averages or the two and-a-half percent margin assumed in our analysis because these providers claim they will be allocating the fixed costs of their health system over a larger base. Any reasonable Economic Analysis doesn't support double-digit marginal profit margins nor do previous CON applications submitted for beds in western Oakland County. However, if one were to believe the argument of higher marginal profits, then it would also apply to other multilocation health systems who would apply for beds under a competitive provision. Another argument made during the last meeting was that these providers already have ambulatory facilities in western Oakland

County and thus they should have the right to provide inpatient care. But other health systems have ambulatory campuses in communities not served by inpatient beds, including western Oakland County. There's no entitlement to beds because a provider already has ambulatory services in a community. Furthermore, the construction costs of one million per bed that was quoted during testimony at the last meeting does not suggest any economies in construction cost for adding onto existing ambulatory campuses. A statement made during the last meeting was that people have to drive long distances for care and that there's no backup for emergencies. Page five of our briefing summary is a map with concentric circles showing existing hospitals with approximately a 20-minute drive time in distance in miles. While this data would be part of the update of the bed need methodology, it does not support the argument that there are no hospitals within a 20-minute drive time of Novi or West Bloomfield. There were a number of statements made that suggested that the capital costs of new construction is not borne by payers and that the health systems are at risk for this. But since these same providers stated that the two and-a-half percent profit margins we suggested in our analysis are too low, this would indicate that someone is paying for the amortization of the incremental capital costs, incremental operating expenses, and profit margin on top of it all. Another statement made was that these providers had a choice of recapitalizing their current campuses or building where the need is, i.e., the capital would have been spent anyway. But from experience and documented examples, we know that the development and maintenance of multiple hospital campuses adds costs for site development, infrastructure and ongoing maintenance and replacement capital and incremental fixed operating expenses. A statement was made that the Detroit-based health systems needs to be in western Oakland County in order to diversify their portfolio. Page six of our briefing summary is a map of locations for these health systems which would indicate a broader coverage range of hospitals and the medical centers in their portfolio than what was portrayed. Finally, there was a statement that these communities deserve inpatient beds. From experience, we know that every community wants a hospital. However, the CON process is designed to look at need. This requires a thoughtful planning process which balances costs, quality, and access and considers bed need based on population and demographics, use rates, drive times, and other important factors. In summary, we are asking that you vote to preclude the implementation of section 3(a) PA 619 that deals with the relocation of hospital beds based on the facts this provision will cause great harm and detriment to the access and delivery of healthcare to the public. Further, we are asking you not to take action on the draft changes for the bed standards as prepared and distributed by MDCH staff on May 28th. Instead, we are asking that you make your highest priority the revision of the bed need analysis. If a revised bed methodology shows a need for beds in western Oakland County, then hospitals should apply for a CON under the competitive comparative review process. Thank you.

MS. TURNER-BAILEY: Are there any questions? Thank you. Patrick McCarty.

MR. McCARTY: Good afternoon, Madam Chairperson and CON board members. My name is Patrick McCarty. I'm the executive director of UAW Michigan Community Action Program. And I'm here to testify in opposition to the proposed CON for hospital and new bed expansion. I understand, looking at your note here, I got five minutes. And I will try to keep this -- I will try to think of something really profound to say like, Commissioners, moving the beds out of Detroit and moving them into Oakland is not going to save Detroit hospitals and save money, so maybe if we remember that. And for the UAW -- and also let me just tell you that if you are getting all kinds of lawsuits and the attorney general is making statements telling you that you guys don't have the authority to make decisions, that's usually a pretty good indication that you are about to do the right thing. Let me indicate two profound things, I guess. The UAW is in a unique position because we wear two hats. UAW are both purchasers and we're consumers. In the state of Michigan, we represent over 450,000 active and retired families. And we have worked extensively on issues like Certificate of Need. And that's why I'm here today to oppose the unneeded new facility of southeastern Michigan. Let me make my comments very clear, Commissioners. Workers and employers ultimately pay the healthcare tab in the state of Michigan. Needless new expenditures and any sort of added costs to healthcare costs is out of reach for more people. It threatens to increase the ranks of the uninsured in our state. We believe, in the UAW, that the CON proposal for new hospitals and expansions unjustifiably accelerate the healthcare costs in southeastern Michigan and across the entire state. There's no need for a new inpatient capacity and the CON for new hospitals. Overall average occupancy rate for the entire state of Michigan is at 50 percent, and the combined occupancy for both hospitals within a 10-mile radii of either of the two new proposed hospitals is about 48 percent. This means that the consumers and purchasers are already paying for the resources that are not being utilized effectively or efficiently as possible. And building two unnecessary hospitals and adding hundreds of unnecessary beds will add unnecessary and needless hundreds of millions of dollars in

construction and the cost of healthcare. Given that the increased number of people in the state of Michigan can no longer afford healthcare, we have to ask ourselves why are we doing this. What begs the question is where are our priorities to best serve. The long-term financial problems facing southeastern Michigan urban health systems is a major public policy problem which is currently being addressed, as we all know, in a separate forum. And in the meantime, the purpose for the CON Commission is to take and make decisions on the basis of community need. We believe, in the UAW, that the broader community's needs will be best served by allowing the urban hospitals -- will not be best served by allowing the urban hospitals to pull up stakes and go to more fertile ground. For example, the poor and the uninsured will receive very little, if any, added benefit if Henry Ford Health System, Detroit Medical Center, St. John's Health System shift resources to Oakland County. The hospitals argue competition in the suburbs will support the urban mission, but promoting competition in Michigan's wealthiest suburbs will likely leave nothing in the urban population worse off. The focus on the suburban profitability is a form of cherry picking that is unsustainable for the health systems and for the health insurers. Both leave the needy behind. Another -- let me just scoot right onto -- because I'm probably within my three or four points, Renee. I'm trying to get -- but in conclusion, since I said two profound things already, the UAW opposes the CON for new hospitals and expansion because it will drive up costs, Commissioners, at a time when affordability and access are the key issues facing Michigan citizens. And we think it will cause great harm and detriment to access and delivery both in the suburban market and in the urban market. Finally, approval of the CON will threaten the viability of the CON regulation as its ongoing concern. The special curved-out legislation punched a hole right through the middle of the CON, creating two sets of standards that the Commission may be unable to reconcile through its normal process. The CON program should remain intact and is a good goal for the community. Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions? Thank you. Bob Hoban.

MR. HOBAN: I'm going to distribute these around the table. It's another correspondence from the mayor of the city of Detroit supporting this initiative, and he's addressed each of you individually. A couple of quick comments -- and I will keep my comments very brief. You've heard why we did propose the legislation in the fall, and I just want to reiterate a couple of those points. And you heard some of them today. You heard two of the Detroit city councilwomen stand up and speak, and we agree with them wholeheartedly. Detroit is in a desperate situation. More than one out of every two people are uninsured or on Medicaid. I would love to draw analogies to the city of Chicago, the city of Denver, the city of Cleveland; but the fact of the matter is we have a higher percentage of low-wage earners, uninsured individuals, and Medicaid throughout the city of Detroit than those communities enjoy. They enjoy some very affluent communities within the city limits of those cities. That's something that unfortunately Detroit experiences a distribution of the poor throughout the city and doesn't have the same level of affluence as some of those cities that were cited. Combined, the Detroit providers are running now about a half a billion dollars a year in uncompensated care. That's not a small number. St. John Health incurs $100 million a year in uncompensated care. We are very, very committed to staying in Detroit. We wouldn't be here today if we weren't committed to staying in Detroit. We wouldn't go through all this time and effort if we weren't committed to remain in the city of Detroit and serving the citizens in the city of Detroit. It's very, very important to us. And it's going to require a multifaceted solution. One of the solutions is clearly giving us the ability to balance our payer mix. It's not the ultimate solution. It is a significant solution, though. We don't expect anybody to come up and cover the cost -- our total cost of a hundred million in uncompensated care. We are a mission-driven organization. We recognize we're always going to have an uncompensated care burden of some significance. That's part of what we are. So to say it's ten million of a hundred million, it's only ten percent, it's insignificant isn't a good analysis. We would be thrilled if we could reduce our uncompensated care burden to 50 million. And then all of a sudden it's now 20 percent of the solution. It's not ten percent of the solution. It is a significant issue. It is significant to the city of Detroit. I'm going to talk a little bit about access to care because you've heard a lot of discussion about Pontiac. Pontiac is a community that has been declining in population and has three hospitals with over a thousand licensed beds. It's had the issue on the table for a number of years, are there too many hospitals in the city of Pontiac. When we did a preliminary analysis, looking at both the West Bloomfield site that Henry Ford was proposing to relocate beds to as well as the Novi site that we're proposing to relocate beds to, drew a ten-mile circle around those two sites, the impact on the Pontiac hospitals was less than 2,000 admissions a year. That's not going to make or break an individual hospital. Their issue in Pontiac probably has a great deal more to do with the number of licensed beds in Pontiac and the fact that we still have three hospitals competing for a declining share of the market in Pontiac. Also, once again, Oakland County, we hear about the bed surplus in Oakland County, number of unused beds. Divide the county right down the middle. The

population in that county developed in the eastern quadrant of that county in the early years -- in the southeastern quadrant, actually, where most of the hospitals are located. If you went out to the Novi area in 1970, you wouldn't have found a lot of population or a lot of housing there. The problem we have is that as the population shifts, the Certificate of Need standards haven't allowed us to move and address the needs of those populations. There's one of the thirteen hospitals in the western half of the county. Twelve of the thirteen are on the eastern half, almost every one of them in that southeast quadrant. It's just that CON has frozen people's feet in place. And we can talk about revising the bed need standards. We just went through that, I think, about 18 months ago. People keep putting that out that that's going to be some magical solution. We just went through that process. We would be happy to go through it again; but in the past, it hasn't addressed this issue. And this issue needs to be addressed. A couple other things I want to talk about real quickly and get to a key discussion around 3(c). That is of concern to you, I'm sure, and we haven't heard a lot of discussion on that. Let me touch on costs. I'm sorry we haven't had the chance to talk to many of the members of the Economic Alliance and meet with their boards individually and their leadership individually on this issue so that we could have some discussion about how this impacts costs. I'll tell you right now that if we move forward with this proposal, it will reduce the cost of healthcare to the employers. We do not get reimbursed capital costs. We do not get reimbursed operating costs. As a matter of fact, largely what goes on is the negotiation process with payers based on market presence in a geographic area. And the fact of the matter is, if you bring more competition into the area, the hospitals are going to lose some leverage with the large payers, the largest one being Blue Cross. And it will probably bring down the overall cost of care to the third-party payers and to the employers. It's not going to ratchet up the cost of care. It will probably reduce it in the end. New construction is cheaper than renovation. Many of the people you heard up here tonight -- I'm sorry -- this afternoon and this morning opposing this have spent hundreds of millions of dollars on renovation. New construction is more efficient than renovation. It's actually cheaper in the end to renovate and build new. So it's about the city of Detroit; it's about access; it's about cost. Also you've heard a lot of discussion about staffing. We're talking about transferring beds. That's another thing that gets lost in the discussion. We're not adding new beds. We're transferring 200 beds from Oakland County from the southeast quadrant to the western part of the county. We're not adding new beds to the equation. Staffing, because of the presence of residents in Novi at our Southfield facility right now, we're looking at a total staffing of 230 nurses out at the Novi facility. One hundred and fifty of those would have come from our sites already. So we're not going to create this inherent nurse shortage that a lot of people talk about. The vast, vast majority of the nurses would come from our existing locations. Let's talk a little bit about 3(c), because I know you are very concerned about 3(c) and the statewide impact. All of you have received an analysis from me a couple of weeks ago looking at 3(c). You just passed the standard that allows hospitals to move from hospital A to hospital B within a subarea. When you look at that analysis and look at the impact of 3(c) beyond that subarea move, moving outside your subarea but staying within your health service area, it gets to be a relatively limited number of moves that you could do that aren't permitted by the standard that was just passed this morning. And then when you look at the occupancy of the hospitals that are involved and the potential move across subregions within an HSA, there's absolutely no reason to do it. You are in a situation where you have a hospital with 50-percent occupancy moving beds to another hospital with 50-percent occupancy. Why would you make the move? There's absolutely no reason to. And if you look in detail at that analysis, although 3(c) appears ominous at first, the number of moves that are going to occur could be counted on less than one hand in the entire state of Michigan. So for all the fanfare and all the exaggerated numbers about moving 20,000 beds, et cetera, that's attention grabbing and that makes headlines; but the fact of the matter is the impact of 3(c) statewide will be minimum. The fact of the matter is, this bill isn't going to cause undo harm to access to care. If anything, it will keep health systems in Detroit. It will enhance access to care in the city of Detroit, and it will not limit access to care in eastern Oakland County. That will not happen. With that, I'll open it up and ask if there are any questions.

MS. TURNER-BAILEY: Any questions? Thank you.

MR. HOBAN: Thank you for the time.

MS. TURNER-BAILEY: I think because we don't have a clock, it's not clear exactly when we hit the five-minute mark. So maybe the department can give us a little signal for each speaker. When we start getting towards five minutes, Brenda or Larry will let you know. I just figured that out. It's because we don't have clocks, and that's the problem. Bob Davis.

MR. DAVIS: Thank you very much, Ladies and Gentlemen, for giving me the opportunity to speak today. My name is Bob Davis, and I'm the president of North Oakland Medical Center in Pontiac. And I want to make your job fairly easy. I realize you've listened to a lot of testimony. I'm not going to bore you to tears. We obviously are very much opposed to the movement of beds from Wayne County to Oakland County for a lot of reasons that I think have already been expressed many times over. There are only a few points that I would like to make, and I'll be very brief. One is that the position of the Commission over the last 15 years has been one that there have been inadequate number of beds in Oakland County. And I would submit to you that nothing has changed. There are inadequate number of beds in Oakland County. But I don't think that anybody here, after having listened to the testimony, could believe that adding new beds into a county that's already overbedded is going to be a financially responsible thing to do. Again, I would suggest to you that the real problem here is the Medicaid program, the lack of reimbursement, and the lack of programs that successfully address the whole issue of the uninsured. And as has been pointed out by people both pro and con, many of the hospitals in Oakland County do have excess capacity including our own. And we would be more than happy to work with any of the systems to utilize our beds that are currently available and waiting for patients. It seems to me to be an entirely irresponsible point of view to simply gloss over the fact that we have these resources bought and paid for by the health payers and the insurers and the employers that are not being used properly at this point in time. I would submit to you that before we try to move or transfer beds from one county to another, that some thought be given to how we might utilize the resources that already exist. It is not uncommon for hospitals to share resources. My recollection is Blodgett isn't in Macomb County right now, but they share a facility with the Mercy organization. And somehow that has gone on for a number of years relatively successfully, I would guess, but not so successfully to create any of the financial issues that result in the overall operation of hospitals downtown. So my thought and the thought I would leave you with -- and I appreciate this opportunity -- is that there are beds available and can be used. And I would be happy to negotiate a lease arrangement with anybody who wants to come and talk to me. Thank you.

MS. TURNER-BAILEY: Thank you. Any questions? James Ball.

MR. BALL: Good afternoon, my name is -- as I said earlier, my name is James Ball. I'm assistant director of healthcare plans for General Motors Corporation. I'm appearing in that capacity and not as chair of the ad hoc. I'm appearing today to urge the Commission to exercise the authority granted to it under Public Act 619 and further to block implementation of the hospital bed relocation exception created in subsection 22209 sub (3). Regarding the issue of whether you should act at all, I would urge you to do so. I recognize that there is an assistant attorney general's opinion that there are legal impediments to action; but it is just that, an opinion and one likely to be tested by court action regardless of whether or not you decide to act. The legislative history would show that the provisions in question were compromised arrived at in the final hours of the last session of a lame duck Legislature and had very narrow support. A clear reading indicates that it was predicated on there being an opportunity for a more complete examination of the issues by those with greater expertise. Indeed, the Legislature expanded the Commission, in part, to facilitate that review. If the Legislature wanted your review and concurrence before the inception could take effect, then if the attorney general's opinion prevails, it is reasonable to expect that the entire subsection would be struck down. In that case, a new Legislature, should it decide to take the issue up again, would have the benefit of your review and action. If you decide to act and the opposing opinion prevails, you will have fulfilled your assignment. Seems to me the worst-case scenario would be for you to not act, to have the opposing opinion prevail, and through inactions to have forever lost the opportunity to preclude an unwise action. Assuming that you accept the opportunity provided to you by the last Legislature, I would urge you to find that the relocation of licensed beds under subsection 3 may cause great harm and detriment to the access and delivery of healthcare to the public, the regular CON statutory criteria tied to an unmet need in the area proposed to be served by a project. In creating a potential exception -- and I emphasize, it was only a potential one because it was contingent on your review -- the Legislature did choose to set aside the normal criteria. Significantly they did not set a measure or require a definitive showing. One must assume that their use of "may" was intentional. Their showing a potential great harm and detriment would be sufficient for you to set the exception aside. If there is any likelihood of harm, the exception should not stand. Now, what would lead GM to conclude that the exception may cause great harm or detriment to access or delivery? While the exception is broader than the Metropolitan-Detroit area, much of the attention in recent days or weeks has been focused on the announced intentions to create two new hospitals in Oakland County and to significantly expand an existing one. So I'll couch my remarks in terms of those proposals. The first issue is the cost of new hospitals. Creating two new hospitals and expanding one has been estimated to require half a billion dollars in capital costs and some 200

million in annual operating costs. While proponents would argue that the direct capital pass-through that existed in the past has been removed, those additional costs have to be captured somewhere. The answer is it will be captured for the payers for services. To the extent that increased costs drive payers to discontinue or reduce healthcare coverage or private purchasers to forego care, access is harmed. There are costs to the existing hospital. Adding some 600 beds to an already overbedded area will impose additional costs, as you've already heard, on existing hospitals that may ultimately be reflected in reduced access and/or delivery of care. What the CON concept seeks to do is just the opposite, to intense utilization of existing capacity in order to lower costs and improve quality and access. Ironically, the hospital seeking to expand is currently operating at about 70-percent occupancy and is likely to see its own performance deteriorate if the exceptions stand. From a quality of care standpoint, it's not clear what services the proponents will offer at the new facilities if they are established. One can only imagine that they will seek to expand items with high financial returns such as cardiac services. Some of these services are volume sensitive with a demonstrative relationship between high volume and high quality. To the extent volume at the various institutions is diluted, quality of care will be harmed. Finally, resource allocation. One reeks of the problems hospitals experience in attracting and retaining qualified staff. Adding new hospitals will exacerbate this problem. It may also result in a flight of staff to the suburbs with resulting harm to access and delivery in Detroit. There is an existing technical subgroup of the hospital bed ad hoc that is looking at appropriate adjustments to the bed need methodology pursuant to your direction. In that regard, I take exception to what one of the previous speakers said of having just gone through a revision of the bed need. If you'll recall, what we were doing was updating the existing bed need to accommodate more current data; but after we had done that, your instructions and your charge to our committee was to review the issues surrounding that need and determine if there should be adjustments made to the methodology of calculation. And so I would disagree with one of the previous speakers on the issue that we have just gone through this process. In fact, you have, as a charge to our ad hoc, to be completed this fall. None of the Detroit area proponent hospitals claim that there is an unmet need in the area to be serviced. It would be hard-pressed to do so, and the combined occupancy of the existing hospitals in the area for 2002 was on the order of 48 percent. All three claim that they want to pursue payers in the suburbs and will subsidize indigent care in the city. And you have heard and received testimony to controvert that claim. One will tell you that affiliated physicians want their own more convenient facility because they are unable to obtain admitting privileges at the existing underutilized hospitals in the area. A solution to the uncompensated and indigent care issues common to many cities is a worthwhile objective. Finding ways to drive cooperation among components of what is essentially a public resource is also a worthwhile objective. But the former is not the function of CON, and the latter is actually harmed by creating exceptions to the principle of matching increases in capacity to the unmet need. Thank you for the opportunity to comment.

MS. TURNER-BAILEY: Are there any questions? Thank you. Vin Sahney.

DR. SAHNEY: Good afternoon. I have testified here on May 28th as we were asked to do. So today I'm not going to touch on all of the testimony that will be submitted in writing. We have about ten physicians from the system who provide care in West Bloomfield. Surgeons, emergency room physicians, support from the community, all of that testimony you already have. So I'm going to make comments on the issue that you have been asked to vote, and that is an issue of great harm and detriment to access and delivery of healthcare to the public. So I will limit my comments just to that particular issue, as per your instructions. There are five issues that I see there. One is, will movement of these limited beds cause detriment to access in Detroit? And I would like to address that. Second, supporting access to primary care safety net hospital in Detroit. Third, will movement of beds to Oakland County cause a problem to access in Oakland County. Fourth, the role of Detroit Healthcare System in training professionals to deliver care, which was an issue brought up by -- shortage of nurses issue that was posed by previous speaker. And finally the importance of medical research and delivery of care. So we've got five key points. And I will just briefly touch on them. You have more detailed testimony that you will be getting copies here. Now, I want to remind you that Henry Ford has a revenue of close to $3 billion a year, 3 billion. It has in the downtown Detroit a revenue of $750 million, in which we lose about $50 million a year. The reason why we can survive there is because we diversified our bill mix by opening satellites in the suburbs in 1975 before anyone in the country was doing that strategy. We built those satellites. We grew those things. And at West Bloomfield, we have close to 200 physicians who practice full time. We have emergency room, operating room, radiation therapy, MRI. We have all of the services there except beds. We do not have beds there. So what we must do is transfer these patients to downtown through emergency medical. So insuring access to Detroit, let me address the four or five points

that I mentioned. Legislature, in our discussion with them in formulating the PA 619 -- but not allowing more than 35 percent of the beds to be transferred at one time. So that means given that we have 903 beds in Detroit, a maximum we would be allowed to move is 300 beds from Detroit. Economic Alliance, who has had five speakers already spoken in spite of the two-speaker instruction, has 1,600 access licensed beds in Detroit. It's in their statement and Michigan report of 2002 December. So moving 200, 250, or 300 beds certainly would not cause access problem according to Economic Alliance. So that's my first point. Second, supporting safety net hospitals. Let's think about what will happen if you don't approve this thing. There is a history of 20 hospitals that have been closed in Detroit. And our friends from Trinity, who are very sympathetic to our plight and I appreciate that, did back up two of the hospitals, closed them in spite of having a profit of 120 billion in the system. They left the city. They closed both hospitals. They now have a solution for us? The Detroit hospitals currently provide over $500 million of indigent care. We are working with the governor as we speak to try to find solution for the safety net, but that solution will not be enough regardless of what you are saying. We have to find solutions to solve Detroit's problem. One of the solutions is the safety net hospitals. We are working on it. Another solution is a better bill mix. Another solution is to raise funds from philanthropic services. And we do that. We raise a year about $30 million from philanthropic support. And we are one of the ones who raise quite a bit of money from the community that we provide care to. Over a period of time, if you shut us off from the people who can afford to pay, our ability to raise funds from the community will disappear. These are our patients that we provide care that we can no longer provide care. And this is another point. So this is a third piece of the pie in terms of subsidizing care downtown. Supporting access to primary care in Detroit. As I mentioned, in Detroit, 23 hospitals have closed over the last 20 years. And during that time, we have built federally-qualified clinics. We have built school-based clinics. Currently we have over 20 schools in which we provide school-based nursing. These funds we have raised through Kellogg Foundation, some of our own institutional funds. If we have no support and we have no means of making income, these things will dry out. So I think you need to think about if you decide not to support us, what will the consequences be three or four years down the line. Today it's DMC. Tomorrow it will be Henry Ford and then St. John, and no one will be left there. Let me shift for a minute to access in Oakland County, because if there's not a detriment to Detroit, perhaps there's detriment to Oakland County. In Oakland County, access would include the development of inpatient capability at facilities that are currently located in the high-growth western community. You heard Bob Hoban testify that if you divide the county in half, Oakland County has a population of 1.4 million. We are providing access to 700,000 people that are on the western side of OaklandCounty. That's bigger than most other cities which have four or five hospitals. Without inpatient bed, these patients suffer a broad range of access problems. We brought physicians from the emergency room the last time, and they testified. These patients cannot have their own doctors when they require hospitalization. These patients do not benefit from the coordination of care and if there are medical mistakes associated with multiple hand-offs and the continuum of care. These patients do not benefit from the integration of inpatient care and the Henry Ford Health System electronic medical record. As I mentioned the last time, it's one of the few systems in the country which has electronic medical record that spans all of our ambulatory care facility and the hospital. These patients and their families must tolerate unusual traffic and difficulties when hospitalized. I understand one of the speakers pointed out that one could reach from Novi to Pontiac in 20 minutes. I challenge them to drive that at 8 a.m. and see whether they can get there in one hour. Emergency care is unnecessarily expensive to the community, and insurance costs are cheaper than hospitalizations provided at the site where the ER care is given. And we have had an emergency room at West Bloomfield since 1975. And we receive 30,000 emergency room visits there. In a broader sense, concerns that much additional costs will be added to healthcare system in Oakland County is unfounded since you already passed a bill that you can move beds from one place to another, and you don't think that will cost any additional expenditure. Next let me address the point of delivery of healthcare.

MS. TURNER-BAILEY: Dr. Sahney, I'm going to have to ask you, please, if could wrap it up. I'm sorry.

MR. SAHNEY: One more point. I know, but you also allowed five Economic Alliance speakers to speak. I will summarize since you already have. I think I need to point out that Henry Ford trains 545 nurses a year in our facility, more than anyone else. We train 850 physicians at Henry Ford Hospital, more than any other hospital in the state of Michigan. These are significant numbers. This can harm -- this can harm -- if you don't help us, this can harm the training of those. Last year we received $183 million in research funds. Your action to deny us this can cause us harm in terms of ability for us to attract this. Let me just mention, we have already submitted to you support from Legislature. A lot of things have been said at the lame-duck session. But we have the Legislature sign the petition and submit it to you saying that they still support this action. So in

conclusion, let me just read the last paragraph. Last year the Legislature saw an opportunity to assist in a critical situation that made provision to expediently address unique areas of need. Their actions put more flexibility into the CON process while still keeping it viable. The expansion of the Commission, the opportunity for more communication between the Commission and the Legislature and the ability of the Commission to move more quickly on review standards are all positive changes; and we support that. Henry Ford Hospital has stated on numerous occasions they support CON and we recognize the specific element of services, and our proposed project will be subject to review process. So that's part of this building of hospitals. If we need operating room, MRI, CT scanners, those will all be subjected to the CON process. We are very proud of health system, Henry Ford. We are not asking to be permitted to relocate beds, because Henry Ford is better than any other hospital. We recognize that every hospital plays a role in the delivery of healthcare. We believe that our role is to put our patients first and the training resource for healthcare professionals and to enhance the health status on Michigan citizens by contributing to the medical knowledge and research. We also believe that the citizens of Detroit deserve to have continued access to the same high standard of care that Henry Ford has provided since 1951. The law was passed because the Legislature realized there was a healthcare crisis in Detroit and understood the sense of emergency. The crisis has only worsened since then. And as we predicted when we testified to the Legislature, your support of this law would allow us to move forward on one of the critical important elements of the Detroit healthcare remedial plan. Thank you very much.

MS. TURNER-BAILEY: Are there any questions?

MR. GOLDMAN: What's the occupancy at Henry Ford Hospital?

DR. SAHNEY: Currently we occupy close to 600 beds.

MR. GOLDMAN: Out of 903?

DR. SAHNEY: Nine hundred and three licensed. The facility is 75 years old ago. And we could not put 900 because so many of the rooms are too small. In fact, a year -- three years ago, we had to renovate the hospital. And the architects told us no way you can renovate; you have to rebuild. And that's one of our contentions. We have to renovate.

MS. TURNER-BAILEY: Any other questions?

MR. MAITLAND: Do you think we need three new hospitals in West --

MS. TURNER-BAILEY: That's Commissioner Maitland.

DR. SAHNEY: I don't think so, because already Detroit Medical Center has Huron Valley Hospital located in the western part, so Novi and --

MR. MAITLAND: So you think we need two?

DR. SAHNEY: Yes, sir.

MR. MAITLAND: Why not just one?

DR. SAHNEY: I can't answer that.

MS. TURNER-BAILEY: Are there any other questions? Thank you. Lody Zwarensteyn.

MR. ZWARENSTEYN: Thank you, Madam Chair and Commissioners. My name is Lody Zwarensteyn. I'm president of the Alliance for Health. And we rise today to urge the Commission to exercise its authority in blocking implementation of the provisions for relocations, especially with regard to 3(c) that's been discussed a little earlier but not much. It seems in all the comments, everybody's saying it's all about me. If I were a reporter, I'd think this is about Detroit, this is about Oakland County. That's what we have been hearing too much of. This is about the entire state. The provisions in 3(c) would allow facilities to move from Ludington to

Plainwell, from Reed City to Carson City, from Ionia to Muskegon, suggested that -- at least we would suggest that relocations should come under the scrutiny of Certificate of Need; and that without that, there can be great harm and detriment to access and delivery of healthcare to the public. Relocation should be judged by adequate standards, and that's the job of the Commission. We believe principles of good planning should be used to develop standards by which health facility projects and services can be judged. When the CON revisions were being advanced through the Legislature last fall, we expressed reservations to our west Michigan Legislatures who, in turn, consistently said, don't worry; this is a Detroit problem; we're fixing a Detroit problem; it has no bearing on the rest of the state. As recently as six weeks ago, many of our west side Legislatures said the same thing. It seems like the fiscal agency analysis never mentioned that this does apply to the entire state and that everybody was saying it's a Detroit problem, it's a Detroit problem. It's not. It allows relocations around the state. Our Legislatures unfortunately seem to fail to understand, at least, that it is statewide and that, in fact, if you have unnecessary movements that costs money -- and those costs are borne by everybody. Even when you look at Detroit. It would be nice to say we would like to put a wall around Detroit, a wall around Oakland County and say take care of it yourself, pay your own taxes, pay your own premiums, don't affect anybody else. But that's folly. We all share statewide. There is a problem in the Detroit area. We recognize that. But the solution is something that we would disagree with some of those who would propose to just move excess beds from Detroit to make more excess beds somewhere else. They're still excess, and they cost when you bill excess. Enacted changes in the Certificate of Need statute gives rise to several questions, especially because they're in precise terms that will require definition and yet the whole move is to say we want to avoid CON. Let's get these projects exempted from CON. How are you going to define things like common control? For outstate Michigan, you can move anywhere within an HSA, health service area, if there's common control. What does that mean? Unfortunately, Mr. Goldman's fraternity brother is going to have to solve that one with some of our courts. I've been around CON long enough not to trust the attorneys and the courts on this. I would rather see some precision about what it means. Does it mean that if two hospitals agree to contract with Lodys' Management Firm, that Lodys has common control over those companies? How long do they have to have? The only restrictions on movements for time, beds and anything else related to cities of more than 750,000. I believe there's only one of those in the state. And if demographics keep working the way they are right now, there may not be any in a little while. That means there are no time limits. There's no one-time only, no bed limits or anything else that would apply anywhere else. Anytime facilities have common control, whatever that means, they can move. Common control could be set up with one week and then dissolved a little later on. Things like that really cause some concern. You can do harm. We think that's inappropriate. It is a way of avoiding scrutiny. It's a way of avoiding the type of common sense approach that CON was supposed to bring about. Similarly, movement to ambulatory surgical centers, there is an ambiguity there. You need four separate CON services in order to host a new hospital. What does that mean? It didn't say four distinctly different. It said four covered services. My contention would be one surgical service and three approved MRIs going to a site constitutes four approved services. Is that how we're going to run things? We can build a lot more than the one that you've been told about or the two that have been suggested. The time limits, the lack of restriction, especially for outstate Michigan are something that we believe could lead to harm, where games can be played. We think that it's inappropriate to handle this. The CON process itself can be made to work, has worked, is vital, is changeable. You've changed it many times. There are serious problems in Detroit. We don't want to minimize those, but don't solve it by a fix that applies to the entire state and can do some unwise things. So we urge you to exercise your authority and act to nullify those provisions. Thank you.

MS. TURNER-BAILEY: Are there any questions? Thank you. Larry Horwitz, Economic Alliance.

DR. SANDLER: Economic Alliance has already spoken at least four times.

MS. TURNER-BAILEY: If an organization gets up and says I'm General Motors, I'm not going to tell them you're not General Motors.

DR. SANDLER: They listed themselves, though -- on this sheet, it says General Motors. I mean, General Motors is listed. UAW is listed. JSJ is listed. I bow to the chair, however.

MS. TURNER-BAILEY: Thank you.

MR. HORWITZ: Madam Chairperson, I have a question. Mr. Johnson is our chairman. I'm the president. Later on when we have legal comment, we have our attorney present, is that a separate topic or are you counting two just to this? I'm here to answer the questions on the precise numbers that have been asked, so I'm not going to repeat what I talked about before.

MS. TURNER-BAILEY: I believe it's a separate topic. What I'm trying to do is just get information that is new and useful for today and not have us here until midnight. That's really the goal, not necessarily --

MR. HORWITZ: I'm totally with this. I can do this quickly. I'm Larry Horwitz. I'm president of the Economic Alliance, and Mr. Johnson is chairman. Just quickly on this material, 3(c), Maitland wanted numbers. 3(c), as it passed the Legislature, would allow a total number of 15,578 beds to be moved. We're much more cautious and restricted in our assessment than the department who came up with an 1,800 number. The subarea transfer that you approved this morning as final action would cover 5,213 beds. Those are system-owned hospitals who have all of their hospitals in a given HSA in the same subarea. So, for example, we take out the Beaumont numbers because they got two hospitals in their system, but they are both of the same subarea. That leaves for 3(c) 10,365 beds. Now, do I think that all will move? No. Do I think that some will move? Yes. This is a wide-open change without any criteria or anything else.

Number two, the business -- this is not -- now let's look at the question of Detroit-connected systems; DMC, Ascension, and Henry Ford. They together throughout the state of Michigan have 6,756 beds. Thirty-five percent of that is 2,365. That includes the St. Joseph - Tawas System, the Borgess System, and the St. John System. Whatever this common is, presumably relates to the entire Ascension system. They are all owned by the Ascension company. So that's 2,365 beds. In the Detroit -- those that are physically really in Detroit is 3,000 -- excuse me -- is 1,000 -- I'm sorry -- 3,678, and 35 percent of that is 1,288. But this is not limited to just beds that are in the city of Detroit. It's more than that, clearly it is. Ascension Providence doesn't intend to move any of the beds out of the city of Detroit. They intend to move them from two hospitals in Oakland County to Providence - Novi. So it's more than that. This is way more than the 2 to 400 beds. I gave to Mr. Christensen a copy of a letter that the chairman of the House Health Policy Committee E-mailed to all of you yesterday afternoon. He sent me a faxed copy that evening in which he says -- this is Mr. Stephen Ehardt -- in which he said that the point of all this was something like a total of movement of 400 beds, and he wants you to make sure it's a movement of 400 beds. The only way you're going to make sure that it's a movement of 400 beds -- and he says 200 beds each. I don't know exactly how he got three entities times 200 and got 400 so -- math. But the real numbers -- I don't know how he does that. But the real numbers that you got in the statute are way bigger than that. How can you then implement what Mr. Ehardt says is the intent in the Legislature? How can you do something that doesn't go way, way beyond anything that the three systems -- the three Detroit symptoms say they want or think is wise? It's by rejecting subsection 3 and then deal with the question of the standard. The department has come up with one. We'll talk about that later. That standard, however, does not do what the department just told me it does. It still is way off the mark in terms of restricting it, but that's not the item at this point. Last issue, will this cost anyone any money? In order for these three systems to gain money, it must come from somewhere. They don't have the power to print money or borrow. So the money comes from somewhere. Where will it come from? Since they are going to be in western Oakland County, Medicaid is not going to be providing much of it. There's a very little Medicaid population in western Oakland County, and you can't get there by bus. So it's going to come from the commercial payers and Medicare. It is going to cost and cost reimbursement, though not in automatic capital reimbursement. Cost still figures into the negotiations that Blue Cross has with hospitals under the participating hospital agreement. Those are the points. As far as the east and west, under the Northwest Ordinance Act, the city of Pontiac is put in the exact middle of the city -- of the county. So they are not east; they are not west; they are center. So there are three hospitals there. And Farmington Hills isn't west; it isn't east either. There are hospitals in that area. You've gotten communications from various people that are worried about the negative impact from city officials in Farmington Hills and Redford and other places. Thank you. I think I hit under five.

MS. TURNER-BAILEY: Thank you. Any questions? Thank you. Gerson Cooper.

MR. COOPER: Thank you, Madam Chair. I was wondering if being the first one in this morning and filling out a slip was going to help. My name is Gerson Cooper, and I'm president and CEO of Botsford General Hospital in Farmington Hills, Michigan. For background, let me add that I've been with our independent hospital for 44 years. In the days before health planning acts expired, I was a provider representative and co-chairman of the

Statewide Health Coordinating Council. And Maryann and I served together. I think it was about 25 to 28 years ago. I'm no stranger to health planning. Botsford is a 330-bed community teaching hospital which offers a broad array of general and specialty inpatient and outpatient services, and we are independent. I'm here today to urge the Commission to vote to require projects involving bed relocation as described in PA 619 to obtain a CON before they are initiated. While Botsford has a Farmington Hills address, we can hardly be characterized as an exclusively suburban hospital. About 30 percent of our 2002 admissions were residents of the city of Detroit. Based on the first four months of 2003, we expect that our services to the uninsured will approximate $16 million, at least 75 percent of which will be uncollectible. Medicaid services, which represent approximately ten percent of our volume, will be delivered at a loss of almost $6 million. So we're sympathetic to the plight of the healthcare providers in Detroit who are facing financial challenges due to providing a disproportionate share of uncompensated care. However, we believe that building new suburban hospitals is an inappropriate and irresponsible response to this crisis. The new hospitals proposed by the Ascension and Henry Ford Health Systems will not generate sufficient additional margins to materially offset losses from their inner-city operations. They will, however, have a chilling effect on those hospitals currently serving the population from which they wish to draw patients and will adversely impact cost, quality, and access. Ascension Health is one of the largest not-for-profit health systems in the world with a network of over 75 acute care, long-term and other healthcare facilities in 15 states and the District of Columbia. It's also the largest Catholic health system in the United States. It employs over 87,000 people. At June 30, 2002, the system had total assets of $9.6 billion, generated 7.7 billion of total operating revenue, which resulted in net income of $111.1 million. Total cash realized from operations was $676.7 million. Nationally, their Medicaid percentage equals five percent. St. John Health is a network of nine hospitals in Metro Detroit, three of which are actually in Detroit. St. John Health is a member of Ascension Health. Providence Hospital and medical centers, a member of St. John Health, consists of Providence Hospital in Southfield and a network of more than 25 outpatient medical and specialty centers throughout the Detroit-Metropolitan area, none of which are in the city of Detroit. I would submit that instead of an effort to cope with the immediate challenge of inner-city losses, PA 619 represents the culmination of a decade-long battle to establish a hospital in Novi at the site of a very substantial ambulatory center they constructed on the golf course they acquired in the late '80s or early '90s. Having been turned down through the CON and administrative appeal process and ultimately through the legal process as well, they found their opportunity in the waning days of a lame-duck legislative session. Providence Ascension suggests that the new 200-bed hospital it proposes will generate a margin of $10 million or more. It is, however, totally improbable that a 200-bed hospital could generate a margin of that magnitude especially considering that they are already capturing the outpatient revenue as well as inpatient revenue from those patients seen in Providence Park and subsequently admitted to Providence Hospital in Southfield. Estimates conducted independently by Beaumont, Botsford, and Trinity Health suggest a margin of slightly less than half of that asserted by Providence, and that assumes a margin of two and-a-half percent of net patient service revenue, which is nearly twice the state average. The consolidated net income for Ascension Health for their fiscal year ending June 30, 2002, of 111.1 million was just one and-a-half percent of net patient service revenue. Interestingly, the revenue and expense statements provided by Providence Hospital in their 2001 CON filing for the Novi hospital anticipated net income of 11.3 percent of net patient revenues. The Henry Ford Health System is comprised of Henry Ford Hospital in Detroit; Cottage Hospital in Grosse Pointe; Henry Ford Wyandotte in Wyandotte; Bi-County Community Hospital in Warren; Kingswood Hospital, which is mental health, in Ferndale; and Maple Grove Center in West Bloomfield, which deals with behavioral services; the Health Alliance Plan, managed care company; Henry Ford Medical Group, between 700 and 800 employed physicians; and 31 Henry Ford Medical Centers round out what I believe to be a fair representation of the relative size of the system. They record 1.9 billion in revenues annually and provide 60 million in uncompensated care. Included in their two and-a-half million patient contacts are 30,000 ambulatory surgeries and 65,000 inpatient admissions. They are noted nationally for all levels of care and excellence in research and education, truly an admirable organization worthy of respect and emulation except for their operating results. So what's the point of all this? Both systems currently own facilities in the suburbs, both inpatient and outpatient. So they are definitely not without access to suburban markets. To operate at a reasonable level of efficiency, the combined hospitals will need to generate 32,500 admissions. That number far exceeds the number expected to come from market growth. While some of those admissions will come from the redirection of patients currently admitted to Ascension's Providence and St. John - Oakland facilities and to a much lesser degree at Henry Ford Hospital, these new hospitals will not be able to grow and achieve profitability without taking patients from existing hospitals, hospitals which are valuable community resources providing necessary services. This will weaken existing hospitals, forcing the consideration of reduction or elimination of services. Some hospitals currently struggling may be forced to close. Trinity Health has

estimated that the redirection of patients to new facilities will result in a reduction of $400 million in net revenues to hospitals currently serving those patients, and that seems like a reasonable estimate. At Botsford, the closest facility to the proposed sites, if you use driving time as a measure, we anticipate that we could experience not only an overall reduction in admissions but a deterioration in payer mix as well. Construction of unneeded hospitals in Oakland County will have a negative impact on costs. Estimates of the capital investment associated with the new hospitals approximate $450 million. In a recently filed Notice of Intent, Henry Ford Health System indicated a project cost of $272.5 million with 90 percent of that project to be debt financed. That translates to an annual debt service of $16 million or $195 per projected patient day if they operate at 75-percent occupancy. Surplus capacity drives up aggregate demand and creates over utilization, increasing costs for payers and consumers. Further, new hospitals will greatly exacerbate the already critical shortages in nursing and certain other health professions. Competition for scarce human resources will increase labor costs for hospitals across the region. We believe that there is not a need for additional hospitals in western Oakland County. And the organizations that would benefit from this section of the law have provided no evidence that there is an unmet need in the area. Those hospitals within a ten-mile radius of the proposed sites experienced average occupancy of about 50 percent in 2002 and can easily accommodate anticipated market growth. Residents in Novi, West Bloomfield, and surrounding communities are well served by the extensive and sophisticated outpatient facilities operated by the proponents of the proposed hospitals. Both sites are within a 15- to 20-minute drive of existing inpatient facilities. These are not underserved communities. Further, there are provisions in the law that require the Commission to review the existing CON review standards with respect to the increase, relocation, or replacement of licensed beds. There's an active ad hoc committee which has been examining issues regarding the bed need methodology used in the CON review standards for hospital beds. This work should be completed. If it is determined that additional hospitals or hospital beds are needed, they should be subject to CON review and all applicants given a chance to compete based on the merits of their proposals. There's a real danger that if these organizations are permitted to move beds from Detroit to create new hospitals in Oakland County, access to care for Detroit residents may be impaired. The Detroit Medical Center has recently announced the closure of 300 beds. Under the new law, one of every two beds moved to create new hospitals must be staffed and available for use by patients. Movement of these resources to the suburbs will reduce access to care for residents of Detroit, and the lack of regional transportation systems will make it difficult for them to access other facilities. Clearly, the state of healthcare in Michigan and indeed the nation is one of contrast. We have the capacity to deliver sophisticated care for a myriad of conditions but not the ability to solve the issue of care for the uninsured. This has compromised the health not only of individuals but of communities as well. It has also compromised the health of our hospitals, hindering their capacity to provide appropriate needed care. Uncompensated care and inadequate Medicaid payments affect all Michigan providers. The creation of two new inpatient facilities, facilities which are not needed, is not going to fix this crisis, however. A swift, dramatic, and sustainable change in public policy is essential to ease the problems of cost and access to care for the uninsured in Detroit. The CON process has benefited the citizens of Michigan. As an organization, we have always supported a strong CON law, though there have been times when our business objectives were thwarted by its requirements. We ask that you do not undermine the effectiveness of the program. Make a finding that implementation of these provisions of the act would cause great harm and detriment to healthcare in the region. And I'm grateful, and I thank you for the opportunity to appear before you today and for your attention. I'm sorry that I spoke that quickly. There was a lot of thought that went into all this paper. I wanted to get all my points out.

MS. TURNER-BAILEY: Thank you. Are there any questions? Rose Glenn?

MS. GLENN: I'm Rose Glenn. I'm the vice president for marketing and public relations for Henry Ford Health System. I've spent 20 years in the healthcare industry, and 10 of those in Detroit and 7 with the Mercy System now known as Trinity, part of that time at Mt. Carmel, which is Mercy Hospital in northwest Detroit, which the Trinity System closed in 1990, and the other part with Mercy Hospital on 94 and Connor, which the Mercy System -- or Trinity System closed at the mid to end of the 1990s. I'm here today to tell you that unequivocally Henry Ford Health System is committed to the city of Detroit. The addition of beds to our West Bloomfield campus will allow Henry Ford to balance the uninsured care provided in Detroit with a payer mix similar to those of nearly every other hospital in the metropolitan area, which is critical to our operations in Detroit. Opponents say that the margin that we might earn at the new hospital would not begin to offset the uncompensated care costs in Detroit. They're absolutely right. However, it is still a critical revenue source that when combined with other strategies will be important factors contributing to our survival, but those

strategies must happen now. Because Henry Ford's West Bloomfield Medical Center and St. John's Providence Park in Novi have all the elements of a hospital except beds, building onto them is exactly the same as when Beaumont or other hospitals are given the okay to expand their facilities. In fact, the proposal that you just approved, allowing transfer of beds within a subarea will not come without the cost of adding beds to a new facility. This is very similar to what we are talking about. When we transfer beds to a campus that already have an emergency room, ORs, MRI, CAT scan, et cetera, et cetera. Henry Ford Health System and St. John Health are both committed to their Detroit campuses and will continue to offer the highest level of care in medical and surgical specialties. We have no intention of compromising the services we provide to our Detroit patients. In fact, we invested $200 million in new facilities and upgrades in our Detroit campus in the last five years. And we're currently developing a long-range facility plan that includes an expanded emergency trauma center and renovated patient rooms. The transfer of beds by Henry Ford and St. John will not cause any access problems or delivery of healthcare problems to the public. The legislation insured that access to healthcare in Detroit would not be harmed by limiting the number of beds that can be transferred and by permitting a one-time transfer. In fact, one could easily state that there's far more potential to harm access in Detroit if the new beds are not approved, because the chance of the hospitals closing becomes much more real. Opponents are saying that the further decline of the DMC and potential closure of city beds should force Henry Ford and St. John to stay put and not move beds. If this occurs, it is very likely that history could repeat itself and that those Detroit hospitals could enter the downward spiral already being experienced by DMC. A regional solution is needed to the healthcare crisis in Detroit. Boxing in the Detroit hospitals will cause the access problem in the Detroit, not the transfer of beds which allows for opportunity for balance and growth. The DMC crisis is not a bed issue. This is a money issue. And Henry Ford and St. John are active participants with the State, the City, and DMC in the development of a responsible solution. I implore you to support this legislation and to allow the transfer of beds to our existing campus in West Bloomfield. Any questions?

MS. TURNER-BAILEY: Any questions?

MS. GLENN: Thank you very much.

MS. TURNER-BAILEY: Dave Marvin?

MR. MARVIN: Madam Chairperson, I'm an attorney. Would you like me to be deferred until the legal section?

MS. TURNER-BAILEY: Yes. Actually, the previous speaker was the last card on this particular issue. So we're actually into the discussion phase which our commissioner -- we're actually into the discussion phase of agenda item seven. I know that there was some discussion brought up earlier today, and I asked that we defer until after we heard testimony. So I'm going to rerecognize Commissioner Sandler.

DR. SANDLER: Yes. Thank you. We've heard a lot of testimony. We've heard a lot of testimony, a lot of thoughtful remarks. And understandably this is an important issue to numerous institutions and numerous organizations, and I respect that. However, the assistant attorney general assigned to this Commission did send out memorandums, E-mails on June 2 and June 9th. And he made it very clear in these E-mails -- and perhaps you would wish to read them. I'm not certain if everybody got your E-mail yesterday, but I think you handed it out. Perhaps you wish to summarize it. But it seems -- it clearly indicates that it's your position that -- the position of the attorney general, attorney general's office, that this Commission cannot and should not vote on the language of 22209(9). And in doing so -- I'm quoting you. It says, not defend your position in court -- the attorney general not defend your position and may subject you even to potential personal liability. You go on to say -- here are some of the things that I will let you comment upon. And because of this -- first I would like you to comment on and summarize your E-mails, since admittedly a number of people in the room may not have had the opportunity to know about them. And I would like to make a motion when you're done.

MR. STYKA: Thank you, Dr. Sandler. First, if I could harken back to a speaker about 12 speakers ago, as a person born into the UAW and unionism, I find it sad that I must say that I have one profound thing to say. When you can't defeat the message, attack the messenger. Contrary to implication, my integrity is my capital. I do not get to make a decision here today, and I do not come here to decide policy but as your lawyer. And you've heard much testimony on the effects of subsection 22209(3) on the access and delivery of healthcare to the public. You've heard testimony that the movement of some beds from Detroit to suburbs, suburban

locations will benefit the payer mix and keep hospitals in Detroit, and you've heard testimony that it will harm access and delivery of healthcare to the citizens of Detroit and maybe even to the suburbs. All of these are very compelling, and I know you want to vote. You really want to vote. In fact, if I were you, I would want to vote. But unfortunately, as your attorney assigned by Attorney General Cox, to provide you with the best legal advice possible, I have to inform you of the following. Two issues are presented by Section 22209(9) for the Commission today. First, due to circumstances that could not have been foreseen, the Commission is without authority to act under Section 22209(9) by the very terms of that provision. This is due to the language that states right within the section -- and I will read -- after the appointment and confirmation of the six additional Commission members but before June 15, the Commission could take action on this section. The Constitution in Article 5, Section 6 very clearly states -- and I will, again, read from the provision -- appointment by and with the advice of the consent of the Senate when used in this Constitution or laws in effect or hereafter enacted means appointment subject to disapproval by a majority vote of the members elected to and serving in the Senate if such action is taken within 60 session days after date of appointment. Any appointment not disapproved within such period shall stand confirmed. Because Ms. Landreville withdrew her nomination for this Commission and because the governor was then forced to appoint someone else, Mr. Corey, Mr. Corey cannot possibly be confirmed within the meaning of the language of both Section 22209(9) and Constitution Article 5, Section 6 prior to June 15th. He can take office. He can serve on this Commission. And under the special language of Section 22209(9), it's required that the confirmation on that one provision he cannot act. Because just by the clock, he cannot stand confirmed, which requires 60 days passed. Thus, the Commission does not have authority to act under this section. Secondly, I previously advised you that even if you could act under this section, there are constitutional issues here. Section 22209(9) appears to include an unconstitutional delegation of legislative authority to this Commission and does not provide clear standards in a constitutional manner for the Commission to act under that section. This also nullifies the authority of the Commission to act under Section 22209(9) even if it did pass the problem of the language of this section not being satisfied in terms of there being six new commissioners fully appointed and confirmed. If the Commission does proceed to act under this section, it does so with a couple of risks. And I'm not saying that this an absolute, but these are risks. The first is that the attorney general may not defend the action contrary to the advice of the department of attorney general and if there's a court challenge. So if you proceed contrary to our advice, there is a history within the department -- and I've been with the attorney general for 32 years -- of, on occasion, the attorney general not defending it. Secondly, the potential -- there is a potential for liability that could result if there were damages to one of these systems and they prove those damages in court. This is because under the Government Immunity for Negligence Act, 1964 Public Act 170, we find in section 1407 that you are indemnified as follows: Each member of a board is immune from tort liability from injury to a person or damage to a property caused by an officer, employee, member, et cetera, while in the course of employment or service or caused by the volunteer, et cetera, acting if all of the following are met. And the very first provision is the officer, employee, member, et cetera, is acting or reasonably believes he or she is acting within the scope of his or her authority. In light of the advice that has been given to you by this office on several occasions, orally at the last meeting and in writing on several occasions, I advise you not to take action under Section 22209(9).

MS. TURNER-BAILEY: Are there any questions?

MR. BREON: Yes.

MS. TURNER-BAILEY: Commissioner Breon.

MR. BREON: I just have a question. Being new, I remember when we were sitting through orientation, I asked a very specific question about indemnification. And I think your response, Mr. Styka, was that don't worry about it; it's always covered. So is that what you mean by that, or what do you mean?

MR. STYKA: It's a fair question. I took it in the context at that time, of course, that you would be acting within the authority that is provided to you in the statute. And at that time, I was not imagining that you would be doing otherwise.

MS. TURNER-BAILEY: Any other questions? Commissioner Maitland.

MR. MAITLAND: If you're subsequently proven wrong on your opinion and we don't vote or take action as described in the law, could we be sued for not voting and would you represent?

MR. STYKA: We certainly would represent you since you would be following the advice of the attorney general. Could you be sued? You can be sued for anything. All you need is a filing fee to sue somebody. Is it a reasonable suit? I don't think so.

MR. MAITLAND: As someone who has served on various commissions for the State of Michigan since the 1980s or maybe '70s and is currently also serving on the farm and AG, I've never run into a circumstance where the State has said they wouldn't defend us. And we certainly end up in lawsuits all the time in the Department of Ag. Could you give us some examples of those cases in the last 35 years where the State did not represent the boards or commissioners or appointed State representatives?

MR. STYKA: Not off the top of my head. I could come back with them if you are really serious about it.

MR. MAITLAND: Well, I just wonder if they are the same as to what would pertain to the potential actions that we'd take today.

MR. STYKA: I know that there have been circumstances. I've seen them during my tenure in the attorney general's office where Attorney General Kelley refused to represent various commissions or board members where they did not follow the advice. You know, to go back and reconstruct all that, I could try. I don't know exactly what I'll come up with, but I know I will come up with something.

MR. MAITLAND: And I'm not sure you answered my first question, and maybe you did. I'll ask you again. If we take your advice and don't vote and subsequently you're proven that your advice was wrong, could we potentially be sued or defaulted for not voting when we were supposed to vote prior to the 15th of June?

MR. STYKA: You can always be sued. And what my answer was is that the attorney general would defend you in all aspects, and that because you would have been acting consistent with the advice as to what your authority was under the statute, the State would reimburse you or whatever if there were any damages.

MR. MAITLAND: If we vote and subsequently you're proven right, which I suppose you think that would be good, what harm does it do to vote, because it would not have any power or authority.

MR. STYKA: I cannot anticipate what those harms would be. I know that there are many, many hospitals out there that have taken opposite stands on this whole thing, and there's likely to be litigation no matter what happens. If because of a vote something did not occur in a timely manner, someone could prove some damages from that, that's what I'm concerned about.

MS. TURNER-BAILEY: Are there any other questions, clarification?

DR. SANDLER: Is it appropriate now to make a motion?

MS. TURNER-BAILEY: Yes. You can make a motion anytime you want to.

DR. SANDLER: I just have one more point. Mr. Cavanaugh -- Jim Cavanaugh stated that the former attorney general read his testimony and concurred completely with what our own lawyer told us. The motion I wish to make is, is that this Commission take no vote on Section 22209 subsection 9 in keeping of the advice of Mr. Styka, our lawyer. Thank you.

MS. TURNER-BAILEY: There's a motion by Commissioner Sandler. Is there support for that motion?

MR. GOLDMAN: Support.

MS. TURNER-BAILEY: Support by Commissioner Goldman. Any discussion?

MR. BREON: Are we going to hear from other people?

MS. TURNER-BAILEY: I have two cards from attorneys who I promised to hear from. I'm going to do that during the discussion phase of this. I wanted to give the commissioners a chance for discussion first. And I'm not cutting off discussion by the commissioners. Dave Marvin.

MR. MARVIN: Madam Chairman, Members of the Commission, my name is David Marvin. I'm an attorney with the law firm of Fraser, Trebilcock, Davis & Dunlap. I'm appearing today as legal counsel for the Economic Alliance for Michigan. Others have spoken and will speak to the issue of whether the exemption in Section 22209 sub 3 may cause great harm and detriment to the access and delivery of healthcare to the public and that the relocation of beds should not occur without a CON. I would like to address at this point a different but related issue. And that is the relationship between your action or inaction on subsection 9; and your jurisdiction to consider the new CON standards proposed by the department, which apparently were distributed last week and then another version and then apparently another version today. My observation is that if you decide not to act today under Section 22209 sub (9), to eliminate the exemption that is otherwise in effect under subsection 3, then you won't have any jurisdiction to consider the proposed new standards, because the new standards for relocating licensed hospital beds would be an attempt to adopt standards in an area that at that point would be exempt from regulation under subsection 3. Stated differently, you must act under subsection 9 to eliminate the exemption under subsection 3 if you want to consider the department's proposed standards. The reason for this is that subsection 3 is presently in effect and provides a statutory exemption from CON standards. The language is subject to subsection 9 and if the relocation does not result in an increase of licensed beds within the health service area, a Certificate of Need is not required for any of the following. And it goes on with the standards. So the effect of subsection 3 is to say a CON is not required under those circumstances. You can't adopt standards to govern the issuance of a certificate when no certificate is required. Now, someone may claim, well, the Commission can propose these standards even if they don't have the opportunity to ultimately adopt them as final standards. Any attempt, I think, to distinguish between a proposed standard and the final standard is really not supported in the law in terms of your jurisdiction. It's a very basic governmental and administrative law that all administrative agencies, including this one, are creatures of statute. You have whatever powers derived from the Legislature. And it's your duty to exercise those powers, but you don't have powers beyond what the Legislature gives you. That being the case, if you leave subsection 3 in place and choose not to act under subsection 9, then you don't have any jurisdiction to require a certificate in a situation where subsection(3) says no certificate is required. An analogy -- it might be an extreme one -- would be if the Department of Agriculture decided they were going to start considering proposed standards on my license to practice law. They would say, well, we're not going to pursue it; it's only a proposed standard. They don't have the authority to adopt those final standards; therefore, they don't have the authority to propose them. They don't even have the authority to consider such standards. And so by analogy here, the point is if you need or want to ever consider the department's proposed standards, you need to act under subsection 9 in order to eliminate the exemption that otherwise is in place under subsection 3. And that's the principal point that I wanted to make. I think it would be appropriate to address briefly a couple of the points that Ron Styka made. One, I think it's probably worth observing that it's an informal opinion -- and this is not meant to be a knock on Ron -- but it's not a formal opinion of the attorney general. But also with respect to an opinion on constitutionality, I think you heard before -- and I believe there are copies of handouts that we have with respect to that -- that the delegation issue that is being addressed is a constitutional issue. And the courts have indicated that on constitutional issues, the opinion of the attorney general does not bind an administrative agency. In fact, in one case, one quote is, quote, "The opinion of the attorney general that a statute is unconstitutional does not have the force of law and certainly does not compel agreement by a governmental agency." It's frankly somewhat unusual to see the word certainly in any Supreme Court opinion, so they were quite definitive in saying that is not something that is not binding. That's not meant to be any kind of personal attack. It's simply to say it is not going to be an abuse of your discretion to exercise your judgment to follow the mandate of the Legislature that says you were supposed to exercise in subsection 9. Even though there may be a disagreement as to that constitutionality issue, it's not a binding decision. The other thing that I think is worth noting is that there are courts that have indicated the importance of allowing bodies like this to exercise their discretion and judgment and not to limit it with threats of lawsuit and threats of liability. And so there's actually been precedent for the proposition that any liability would only attach if you are operating in a situation where you have absolutely no doubt that you are taking unconstitutional action. That's a very strong standard. That's even more than the criminal standard of beyond reasonable doubt. A no-doubt standard I don't think anyone could find in very many cases would ever be applied to any body like this or any other one operating in good faith. With respect

to the issue of the confirmation of the newest commissioner, I did hear Jim Cavanaugh earlier quote Attorney General Kelley. I thought the most interesting part was his acknowledgment that his own previous opinion was counter to his testimony today, but he was attempting to disavow that previous written opinion saying it was incorrect at the time. That may or may not be his opinion today; but the point is, as acknowledged in his testimony, a previous opinion did indicate that there could be such a thing as affirmative confirmation. I think it's fair to say that there are different views as to whether or not when the Senate confirms, that constitutes confirmation. It would certainly be my view that if the Senate votes to confirm, that's confirmation. And the Constitution simply says if they don't do anything within 60 days, that that inaction would also constitute confirmation. And I believe that one other thing that is probably worth mentioning is that as I was listening to Ron Styka's comments, he pointed out there's certain risks but they are not really absolute. I think as a realistic matter, the level of risk of a body exercising its good considered judgment under these circumstances would, in my opinion, be very low, given the fact that you're not bound to follow an attorney general opinion on constitutionality. You are bound to follow the mandate of the Legislature. And the Legislature in subsection 9 did, in fact, indicate that it was your jurisdiction and duty to address that issue and determine whether or not the exemption in subsection 3 should remain. That concludes my comments. I would be happy to answer any questions that anyone may have.

MS. TURNER-BAILEY: Are there any questions? Thank you.

MR. MARVIN: Thank you.

MS. TURNER-BAILEY: Pete Ellsworth.

MR. ELLSWORTH: Thank you, Madam Chairman and Members of the Commission. My name is Peter Ellsworth. I'm with the Dickinson Wright law firm. I'm representing William Beaumont Hospital. Like Mr. Styka -- I guess I don't go back quite as far as Mr. Styka does. I have worked in and around Michigan government now for about 30 years. He said 32 in his case. I have worked for the State. I worked for the State for about ten years. During a major portion of that time, I was the principal legal counsel to Governor Milliken. I've been in private practice for about 20 years. Much of my practice deals with both representing State agencies and working before State agencies. I have chaired a State commission that oversees a major department, one of the principal departments in the state. In that capacity, I would venture to say that the commission that I chaired probably got sued more than any other commission because it dealt with State employment matters. It was the Civil Service Commission. We were sued all the time. I was sued personally. I was accused of unconstitutional acts. I was accused of all sorts of things. I always got defended by the attorney general, and I got defended well. I find the advice that you are being given today really rather incredible. What you are being told is that you can't follow a statute. You're told that you can't take a vote that a statute says that you are supposed to take. You're being told that the statute is unconstitutional, but there is no definitive Court decision that says that that statute is unconstitutional. Attorney generals can issue opinions, but those opinions don't have the force of law. Until the statute is declared unconstitutional, it's the duty of a State agency to follow the statute. What you're not being told is that there is lots of Michigan law. In fact, I know of no law to the contrary to the effect that agencies and commissions are not to question the constitutionality and the statue that they are operating under. Case after case has said that the job of commissions is to discharge the duties under the statute and leave it to the Courts to decide whether the basic statute under which you're operating is valid or not valid. And these cases don't just say that it's your choice, that you have a choice in the matter. These cases say you can't consider the constitutionality of the statute, and there is no question under Michigan law that that is the case. If the attorney general is correct or the assistant attorney general -- and this is not a formal opinion of the attorney general, as Mr. Marvin just pointed out. It's a memorandum from a division chief. And it should be accorded respect, but it's not the same thing as a formal opinion of the attorney general. But formal opinions of the attorney general don't have the force of law either. But if Mr. Styka's opinion happens to be correct and a Court so finds later on, then the vote is a nullity. That's the effect, that the vote is declared to be a nullity, nothing more than that. With respect to personal liability, you're not liable if what you are doing is following a statute. The law is clear that it's not your job to decide whether the statute is unconstitutional. Your job is to follow the statute. If you follow the statute and you do so in good faith, you can't be held liable. You have government immunity. The action that you take in discharging the clear mandate of the statute is action which is within your province of State officials. It's acting within the scope of your authority, and there is no question about that. Finally, with respect to this notion that maybe the attorney general's office will not provide a defense, think about the ramifications of that. I know that when I

served as the chairman of the Civil Service Commission, if I had thought that the attorney general's office was not going to provide me with a defense every time I got sued by an employee that was fired or disciplined or didn't like the terms and conditions under which she or he was working, if I thought the State wasn't going to provide me with a defense, I wouldn't have done that job. It was a volunteer job like yours is. I wouldn't have stayed there. I couldn't have let myself be open for that kind of liability. And nobody -- no volunteer and, frankly, a lot of State employees would not put themselves in a position of running that risk. There has been discussion, I understand, although perhaps not this afternoon but in other discussions, about the case a number of years ago in which a number of officials at the old Public Health department were sued in connection with the denial of the Certificate of Need for Huron Valley Hospital. Those individuals were accused of violating antitrust laws. It wasn't violating Certificate of Need laws. It was an antitrust case that was filed to put them in the -- in which they were personally named. The attorney general's office did not defend that case; the State did. The State provided the defense. It was -- the State paid for the defense, but it was my law firm that provided that defense. And I was one of the lawyers in the law firm who defended those individuals. And I can tell you it wasn't a pleasant situation because that was a situation where the suit was directly against the individuals themselves. But there was never a question about whether those individuals were going to be defended or not. That wasn't an issue. Of course the State was going to provide a defense for them because they had acted within the scope of their authority. And ultimately we prevailed in that defense, and nobody was liable for anything. The State wasn't liable. The individuals weren't liable. Had the individuals been liable, the State would have picked up the costs because that, again, goes along with the State's duty to defend. And the State is not going to leave public officials out there on their own or they are not going to have any public officials because people like you aren't going to serve. So my message to you -- and I've known Ron Styka for many years, and I like him and we are friends and I respect him, but I totally disagree with the advice that he's giving you this afternoon. Your job is to follow the statute. If the statute turns out to be unconstitutional, a Court will so rule. And at that point, your decision is a nullity; but that's the only ramification. I would be glad to answer any questions that you may have.

MS. TURNER-BAILEY: Questions?

MR. GOLDMAN: Commissioner Goldman. It seems to me there's two questions here. The first question is a technical question, whether we have six new commissioners who have been appointed and confirmed. And that depends on how you choose to read the Constitution in the state of Michigan. The second question is in some ways a more interesting question, because what it revolves around is a delegation issue. And typically -- tell me if you disagree. Typically a delegation issue goes like this. The State passes a law that creates an agency, and it gives the agency certain powers. And the question is, what did the Legislature empower the agency to do. In this case, the Legislature amended an existing law, signed that amendment. And the Legislature said, we are going to take the following action. We are going to allow certain hospitals to make certain moves under certain conditions. If you guys think that's a bad idea because it will cause great harm and detriment, then let us know. That's how I read the language. That strikes me differently than here's some authority that you can use to carry out a certain act. This is a State Legislature already doing something, saying if you think we got it wrong, you let us know, and then it will be automatically retracted even though the governor has already signed it. That just strikes me as different and as troublesome, because it violates the parts of law school that I was awake for when they talked about separation of powers. And, you know, the State Legislature says we're going to pass a law, the governor is going to sign it; if you guys don't like it, you can nullify it even though the governor has already signed it. Am I making a distinction without a difference or is there a more detailed problem there than the cases that have already been cited to us, the natural resources case?

MR. ELLSWORTH: The natural resources case is a case that deals with the standards that are given to an agency. And I don't view this as -- I'm like you, I don't view this as a case that turns on how clear the standard is. I think that you've been given a pretty clear standard. I think that this issue is a little bit different. And it's a novel issue, and I don't know that we have any case in Michigan that deals precisely with this. We do have some cases that say that it's all right for the Legislature to pass a law and make the effectiveness of the law contingent on the happening of some event in the future. Now, what the Legislature has done here is to, in effect, do that; and that contingent event is the judgment made by this Commission. I don't know -- I honestly don't know, and I can't find any case that really answers the question whether that kind of a contingency is the sort of contingency that a Court would say is okay. But I can tell you that there are cases saying that the Legislature can pass a law that, in effect, doesn't become effective until the happening of some future event.

And I suppose for those who would defer to this law, that's going to be the kind of defense that's raised, which is the other thing. If there's any kind of a defense that can be made of good statute, the history, the track record in the attorney general's office is to make the defense and defend the statue. There are occasions, mind you, when the attorney general himself or herself might not be the one who makes the defense. I've had several cases in the last ten years -- I can think of two in particular where I wound up defending the State because the attorney general didn't agree with the statute or didn't agree with the kind of defense that could be made so chose not to make the defense. My firm was then hired to provide the defense on behalf of the State. And frankly, in both of those cases, the statues were held to be valid. Now, the statutes were okay. The attorney general doesn't have to defend everything. I think you're raising a perfectly valid point, and I'm not here to say that the statute is constitutional. I think there's a significant question about it, but I am here to suggest that that's not your job. Your job is to follow the statute. A Court's job is to decide whether that statute is valid or invalid.

MR. GOLDMAN: So if we follow the statute and we take a vote, either the vote will be to uphold the statute, in which case we haven't done anything that will change the outcome of the way that it currently exists, or our action would be to follow the advice of the attorney general's office and not take a vote, which results in the same end result, it upholds the statute; or we take a vote and we find that there's harm and detriment. And then I suppose if the Legislature doesn't like that, they can pass a new law with the same language. Isn't that true?

MR. ELLSWORTH: I think that's true. And I've heard comments here this afternoon that there may be a distinction between different parts of the statute, there may be different ramifications under sub C than there are under other portions of it. Of course, you weren't given the discretion to parse out -- I mean, it's the access issue itself. But if you send a message back to the Legislature, then it's the Legislature's job to decide whether it wants to reenact something that's tailored differently to address a different issue or not or just leave it there. But it seems to me that the statute anticipates that there will be a vote, be it a vote effectively to find that there's not an access problem, in which case the provision is effective as written, or to decide that there is an access problem, in which case it is not.

MS. TURNER-BAILEY: Commissioner Hagenow.

MS. HAGENOW: You sort of indicated to us that we should be rather outraged that we're not being defended by this vote, by your experience. And yet the difference to me in the circumstances that you talked about where we should be defended is that we have a clear message in advance that this is not appropriate for us to take action on this. So it seems to me when your attorney gives you that advice, then we shouldn't be outraged when they say we're not going to defend you, because we're going to ignore you.

MR. ELLSWORTH: Well, I'm not suggesting that you should be outraged. I'm suggesting, however, that you should expect to be defended if what you do is to carry out the statute. And I have been in situations where the attorney general has indicated disagreement with the constitutionality or the validity of a statute. I wound up in a case about ten years ago that I recall where the attorney general took a very public position and thought that a particular -- it was kind of an oddball law. It was a special purpose law, but the attorney general disagreed the validity of it. I was asked to defend that, but I had a different client that was involved in the same case, so another law firm was asked, with the attorney general's concurrence, to come in and defend the statute. The attorney general had expressed an opinion, but that doesn't mean that the attorney general can overrule the Legislature; and that's what you are talking about. What we're hearing this afternoon is a memorandum from an assistant attorney general, although a well-experienced, very capable lawyer, but from one assistant attorney general, perhaps with the help of some other assistant attorneys general, is enough to overturn a statute. The system doesn't work like that. Courts overturn statutes. Assistant attorneys general and attorneys general don't overrule statutes on constitutional grounds.

MR. SMANT: At the time you were hired by the State to defend a case, were you hired by the attorney general or his department?

MR. ELLSWORTH: In the old Huron Valley case that I mentioned a minute ago, I think that we were hired by the department. At that time it was the Department of Public Health. We were appointed special assistant attorneys general by Attorney General Kelley. And we worked closely with the attorney general's office with

respect to the case. But we were the ones that were actually defending the individuals in the case. Our clients -- we were representing the individuals because the individuals were named individually in the lawsuit. The bills were paid by the Department of Public Health. The attorney general's office obviously cooperated in the defense. And that's been my experience in all the cases I've had where I defended the State. We worked with the special assistant attorney general, and we worked cooperatively with the attorney general whether the attorney general is the one to be directly involved in the case or not.

MR. SMANT: The reason for my question was that in Mr. Styka's opinion, he also indicated that he would recommend that they not defend us. I think that's what's giving great pause to many people on the Commission and, in fact, is that going to fall back on a person, we as Commissioners. So that's an element that we really haven't talked about. So I think that is more of an actual constitutional question as to can we, in fact, be liable for our action.

MR. ELLSWORTH: Well, to be liable, there has to be damage done for one thing. And I don't know at this point what the damages -- and damages meaning actual monetary losses. But that's -- I used the word incredible at the beginning of this. And the part of this that I do find incredible is that. Because if you think about the ramifications -- and I can tell you there's no -- you know, in all honesty, if the State wants to walk away and say we're not going to provide a defense, then I suppose the State can do that. It doesn't happen. And if you think of the ramifications of it, I mean, nobody is going to serve if the State ever fails to defend people who are acting on behalf of the State. I can -- Mr. Styka was asked of a situation --

MR. STYKA: I've got one for you.

MR. ELLSWORTH: I've got one, too. Do you want to go first? Because I can site one. I don't know the individual, but I can remember the circumstance. It had to do with a scandal a few years ago in the House Fiscal Agency where there were some individuals that quite literally were stealing from the State. They weren't acting on behalf of the State. They were doing dishonest things. They were -- a couple of them were eventually prosecuted criminally. The State didn't provide a defense to those people. But in instances where State workers or State commissioners or State department directors are following the dictates of the statute, you are acting within the scope of your responsibility, you're doing what the Legislature expected you to do, if the statute is not constitutional, it's not your fault. You're doing your job. You're following the mandate of the statute. In those instances, if the State doesn't defend people like you, then there aren't going to be people like you doing this kind of a job in the future.

MS. TURNER-BAILEY: Are there any questions? Mr. Styka, did you have a comment you wanted to make?

MR. STYKA: I have a lot of comments. In fact, what I'm doing today is asking you to follow the statute. The focus of the -- first, remember your attorney is the attorney general, not counsel hired by particular parties with a particular point of view. We heard from three attorneys today outside of your own counsel; one who was hired by the St. John System, who spoke entirely supportive of what I've advised you. You heard from two, one from the Economic Alliance and one from Beaumont, who are opposed. They are on the opposite side, who have taken the opposite position in the law. You are not a Court. You are a body who is proceeding under the CON law in accordance with its terms. And your legal counsel is Mike Cox, who has assigned me to be here with you, not these other individuals. Mr. Marvin, when he got around to speaking about the advice that I've given you, he mentioned the citation of opinions that say that the attorney general's formal opinions are not binding necessarily. The opinions that are cited in the memorandum that you were handed, which is the Mike Ashton memorandum, I looked at those. It has always been true that the attorney general's opinion is not binding on the Courts. And I read those opinions, and that's what they reference. They don't reference them not being binding on the agencies. They reference them not being binding on the Courts. You have to really strain to come to the other conclusion. So they say nothing new or different to this Commission. With regard to opinion number 6120 that was referenced -- that's the one that Jim Cavanaugh referenced -- I brought that opinion with me. Actually, that opinion throughout consistently, as all of the other opinions of the attorney general, the five previous ones, takes the position that a person is appointed and confirmed when the 60 days expires. Only in one sentence does it say something slightly different where it says has not been approved by -- and this is at the end -- by the Senate, an implication being that there was an opportunity for the Senate to actually approve. Previously, just two paragraphs up, it says, inasmuch as under Constitution 1963, Article 5, Section 6, the appointment of a State officer is not complete until the expiration of the 60-

session day period following the appointment. It's very clear this opinion is consistent with all the others. It may have a sentence that's out of line that some editor didn't catch, but it is consistent. And I'm asking you to follow the statute. There may be issues that can be argued by attorneys concerning the constitutionality question, which I stand behind. But on the issue of whether or not Mr. Corey is able to vote on the issue, the answer is no. And because the Legislature very narrowly gave you authority to act only if the governor appointed six people timely enough for them to be confirmed with the 60-day passing and then by June 14th, you're in a box that you can't get out of. The fact is that Mr. Corey does not become confirmed in time. And nothing personal, Mr. Corey; it's not your fault. And as a result, this Commission, if it follows the statute, has no authority to act under Section 22209(9). So you would be doing what these lawyers said, following the law. It was talked about by Mr. Ellsworth whether or not there was any case law dealing with issues of, as Mr. Goldman questioned him, the strange way the Legislature set this up. The Legislature delegates to agencies all the time. It delegates to you the authority to come up with the standards on specific review areas of Certificate of Need. However, the Legislature does not -- or cannot, rather, give away its power. And in the case which I cited to you and the opinion that Nancy Cassis also passed onto the Commission, in that case, the Supreme Court stated that the Legislature may enact a bill of law to take effect upon the happening of any future event, which was discussed by Mr. Goldman and Mr. Ellsworth. Certain or contingent, which does not involve -- this is the key -- exercise by others of that legislative will and discretion which cannot be constitutionally delegated. What the Legislature did here is actually delegate to you its will and discretion as to this issue of harm. And that is a big roadblock in the constitutionality of that provision. But putting aside the constitutionality of that provision, you are stuck with the first roadblock; and that is the fact that by happenstance, you are unable to vote under the very law that we're talking about because you do not have six commissioners that have been confirmed in time to give you that authority to vote. Mr. Ellsworth was asking, as you had earlier -- as Mr. Maitland had earlier about specifics. I was involved in the specifics when it dealt with the Certificate of Need. Prior to the current law, par 221, which was 1988 and before, there was a board called the Opinion Review Board -- I mean, the Certificate of Need Review Board. And that board did not create standards but instead was the first-level appellate body on Certificate of Need matters. So if someone applied for a Certificate of Need and they were denied, before going to court, they first went to this board. That board made decisions that appeared to be strange under their legislative authority. They were sued by me on behalf of the department for that. And the attorney general who was assigned to represent them, who represented them in all their matters, my boss, went to court and told Judge Glazier that they were wrong, and he was confessing error on their behalf. So it does happen. And that case eventually went to the Supreme Court, and I won and the board lost. So there are situations, and I was actually involved in one where the attorney general has not defended. In fact, he went to court and said the agency I represent is wrong, your Honor. Do what you will with it.

MS. HAGENOW: What did he do?

MR. STYKA: He ruled against them. That wasn't one with any liability issue. They were represented in that case but not the way they wanted to be.

MS. TURNER-BAILEY: Commissioner Breon has the floor.

MR. BREON: I hope I'm not the only one who's getting a headache from all of this. Just a process question, I guess, more than anything else. I do have a single question; that is, I'm trying to summarize this in my head. We either vote yea or nay on whether we have the ability to vote. And then the secondary thing is that we vote on the statute yea or nay whether we agree with it or not agree with it. Either way, it will probably end up in court at some point. What's the ramification if we don't take a vote, this goes to court, and you're proven wrong? Do we give up our ability to vote on this issue in the future or is that pretty much it?

MS. TURNER-BAILEY: Can I piggyback on that question, because I heard a comment from one of the speakers that said -- assuming you're right -- which I assume you are. If assuming you're right, why wouldn't the vote just simply be nullified later by the Court? Why is it an issue that is, you know, if a hundred percent decided today and if we don't do it, it's -- instead of all these other consequences, why is it not something that would just simply be decided in court later? I hope that piggybacks your question.

MR. STYKA: The attorney general's advice was asked for, and it's been provided. And the attorney general wants his advice followed even if that advice came through me.

MS. TURNER-BAILEY: Right. I understand that. Why can't -- why isn't it an issue of we've done something and then the Court says what you've done is null and void?

MR. STYKA: I guess if you do something, that would be where you would end up. But I'm telling you up front that you don't have the authority to do it.

MR. GOLDMAN: If we do nothing, then hospitals would have to claim they were adversely affected. So hospitals that we've heard from today in Oakland County would have to say that as a result of our failure to act, they were adversely affected. Now, that's a hard case to make, because there's two actions we can take. And one of them is to uphold what the Legislature did, so they would have to say not only did we fail to act, but they believe that we would have acted in a way that would be beneficial to their interests. We've had no conversation or vote on that. So I have no idea how we would vote, you know. So that would be a two-step claim. First we would have to say that we had authority and we should have exercised it; and secondly, that we would have exercised it in their favor. And if we did, our actions would have been upheld; and if they were, the Legislature wouldn't have nullified them later on, which was my point with Mr. Ellsworth earlier. Any action that we take can be subsequently nullified by on the Legislature if they want to. It's an unlikely case. It's possible but unlikely. So what's the other case? The other case is that we vote. Either we vote to uphold what the Legislature did, in which case who cares. There's no increased lawsuit risk. Or we vote in opposition to what the Legislature does. And then the potential plaintiffs are the Detroit hospitals or other people who believe they were adversely impacted. So they would have to claim that our action was improper, and that would be the arguments that you've heard. In that case and only in that case would the attorney general's office be faced with the question of did our actions result in a lawsuit that might not otherwise have occurred and, therefore, would they exercise their ability to say that we acted outside the scope of our authority and, therefore, would not be entitled a defense. That seems to me to be the risk in a nutshell. And I'm not -- I'm clearly not acting as an attorney for this group. That's just as a commissioner, that would be my analysis.

MS. TURNER-BAILEY: Are there any other questions or discussion? I know I have I cards here. And I haven't called them because if you are going to come up and urge us to do one thing or the other, I don't think that's testimony that we need at this point. If you're a lawyer and you have something to say, I think we agree that we would hear those during this discussion, and you can come up and state your statement. You are?

MR. BAKER: I will ask you to decide whether I'm a lawyer.

MS. TURNER-BAILEY: I don't want to make a judgment on who's a lawyer or not. Are you Michael Baker?

MR. BAKER: I'm Michael Baker. I'm a Kentucky attorney who was admitted to represent St. John as an applicant in the Certificate of Need case that's still pending. I am not a Michigan attorney. With your permission, I would like to make a couple statements but only with your permission.

MS. TURNER-BAILEY: Go ahead.

MR. BAKER: Okay. And most of what I wanted to say Mr. Styka said in the last round, so I won't repeat that. It's just a little bit of background. I've practiced Certificate of Need law now for almost 25 years almost exclusively. And for the last nine months or so I've been pro bono counsel for the American Health Planning Association, which if you are not a member, you should be involved in. We're going to be in Nashville in August. But one important thing that has not come out in this discussion of whether we should follow the statute and what happens if we don't follow the statute, the one thing that I don't think has been mentioned is the statute doesn't say you shall meet or you shall hold a hearing or you shall take a vote before June 15th. The statute may or may not give you the authority to take a vote, and that's what your counsel has advised you on. The statute doesn't say you shall or it doesn't even say you should. So on the question of if we don't vote, do we stand to be sued -- and as Mr. Styka told you, anybody can sue over anything, but no one can find a word in that statute that says you have a duty to even hear witnesses much less take any kind of vote. So I think whatever concern you have over that is just something that should not come into play in making your decision.

And of the administrative veto power that seems to be in subsection 9 is something that's very unique. I haven't seen it anywhere in any Certificate of Need law anywhere in the country in the last 25 years. So that's something that's very unique. I believe you have it analyzed pretty well. It isn't a matter of making a law contingent upon some future event occurring. It is passing a law saying we're going to delegate the veto power over that statute for administrative agency. I believe that is something that is a very questionable authority. But whether that delegation is constitutional or not is not the question before you today. Mr. Styka has told you that if you follow the statute, you don't have authority to take a vote, because the conditions in the statute to taking this action have not occurred and cannot occur before the deadline. So I think that's the most important advice that you've had before you. And if anyone says that you have to follow the statute, yes, you do have to follow the statute. But if you follow the statute, it doesn't pose any duty to take a vote. And as your attorney has advised you, the conditions required for you to do that have not occurred. I believe Mr. Ellsworth, who I've met a few times in the CON case up here, is a very fine lawyer and has been doing this in Michigan longer than I have in Kentucky. But I believe when he was asked about firing someone, that if the counsel assigned to him had said you don't have the authority under the statute to fire this person, that he probably wouldn't have acted to fire that person. And that's the analogy that he chose, which I think is very important here. So I just ask you do what you believe is the right thing to do, but you should listen to your lawyer. Thank you.

MS. TURNER-BAILEY: Thank you. I apologize for the timing, but I've been told that our court reporter needs a break. Ten minutes. (Whereupon a brief recess was taken.)

MS. TURNER-BAILEY: We're reconvened.

DR. SANDLER: Commissioner Sandler would like to call the question so we can move on with other points of our important agenda today.

MS. TURNER-BAILEY: I will call the question. And I have a couple of more cards that -- the commissioners have indicated to me that they're interested in discussion amongst the commissioners and that we can pull in. Otherwise, I would have let people do it before. I understand what you're saying, and this is a little different from a regular discussion that we would normally have on a motion. But I told the lawyers that they would have to wait until this point in time. We have two more. Raj, are you going to speak as a lawyer?

MS. WIENER: Thank you, Madam Chair and Members of the Commission. I just have two very brief points to make.

MS. TURNER-BAILEY: Introduce yourself and sign in.

MS. WIENER: Yes. I am Raj Wiener, and I'm with Wiener Associates. I'm an attorney that represents a number of health interests in the state, two of which are hospitals that are in Detroit. I just have a couple of brief points to make. And the first one is that there's only one attorney in this room who is not seeking something from this Commission. All the rest that you've heard from, including myself, represent somebody, an interest, whatever, and we would like to persuade you. I don't want to talk about those legal issues as much as I want to tell you that Ron Styka is the only attorney in this room who isn't looking for something out of the Commission. Ron Styka was the assistant attorney general when I was the Public Health director and I ran the Certificate of Need program. And many of the other attorneys that you've heard from who are giving you good advice here today are the same ones who deposed me for hours and hours and hours and run suit after suit after suit against the State. And I sure would not want to be in that room without my assistant attorney general back then or now and neither should you. I don't think you would go against the advice of your own attorney on a private matter. I don't think you would go against the advice of your attorney if you were on a private board. And you're on a State board, and this is a State attorney general giving you advice. And if I were you, I just wouldn't want to be in that room without your assistant attorney general. Thank you.

DR. SANDLER: I'm saying she left out Mr. Goldman. He represents the people in the State, presumably.

MS. WIENER: I stand corrected.

MS. TURNER-BAILEY: David Marvin.

MR. MARVIN: I have concluded my comments, but I just wanted to explain that we received just in the last five minutes a memo from the Senate Majority Counsel, Fred Hall, addressed to Senator Shirley Johnson dealing with the issue of the confirmation of Mr. Bradley Corey to the CON Commission. And I believe copies of that have been distributed. I think it's significant to note he goes into some detail as to his opinion as the Majority Counsel to the Michigan Senate, and his opinion is that Mr. Corey was properly confirmed by action of the Senate. The explanation and rationale is there as well as a rebuttal to the assistant attorney general's position.

MR. DELANEY: Except he misspelled his name.

MS. TURNER-BAILEY: Okay. Any questions? Okay. Is there any further discussion on the motion that's on the floor, any further discussion? Commissioner Maitland.

MR. MAITLAND: Could you repeat the motion.

DR. SANDLER: I think we may have to clarify as well.

MR. ROGERS: The motion was to not take a vote on 22209 --

DR. SANDLER: I would like to change that to not take a vote on Public Act 619. I would like to make it more general. Not take a vote on Public Act 619.

MS. TURNER-BAILEY: Public Act 619. Except for there's a lot --

MR. STYKA: I think your first motion made more sense than the first.

DR. SANDLER: I will defer to the lawyer, then.

MR. STYKA: It would be under, not on.

DR. SANDLER: I would defer to the lawyer.

MS. TURNER-BAILEY: Commissioner Maitland.

MR. MAITLAND: I guess -- I mean, I think that this thing that we were just handed, which I haven't had a chance to read, is somewhat significant, because part of the whole process is whether we would have the ability to vote because of the appointment. So I'd like Mr. Styka to respond to this Fred Hall, who's with the Senate Majority Counsel.

MR. STYKA: Well, I read it as quickly as I could. Basically it cites an authority and basically says I'm wrong because he says so.

MR. MAITLAND: Isn't that pretty what you say all the time?

MR. STYKA: I believe I cited authority, Mr. Maitland. Basically the Senate counsel was saying he wants the Senate to have the authority to positively confirm people no matter what the constitution says, which I can understand why he wants that.

MR. MAITLAND: I have a second question, if no one else has a question.

MS. TURNER-BAILEY: Go ahead.

MR. MAITLAND: In paragraph nine -- the counsel for Kentucky, I guess, said that we don't have a mandate to vote. But, you know, I'm just a simple person from Traverse City. When I read -- and if you just leave out the confirmation part, it says, if seven or more members of the Commission determine that relocation of licensed beds may cause great harm, how do we know -- I mean, they are asking us to take a vote. They're telling us

to take a vote; otherwise, we don't know if seven or more determined that there's great harm. I guess I need an explanation, because to me, that says we have to take a vote to take a count.

MS. TURNER-BAILEY: That actually comes back to the original question, doesn't it?

MR. STYKA: I do not read that as a mandatory requirement that you take a vote. It simply says if seven or more vote, then ex. It doesn't say you shall vote and if seven or more vote, then ex. It is simply a possibility.

MS. TURNER-BAILEY: Yes. Mr. Ajluni.

MR. AJLUNI: On Dr. Sandler's motion, would simple majority carry that motion?

MR. STYKA: Yes.

MR. AJLUNI: And I hate to ask such a question after all the discussion, but does Mr. Corey vote in that instance or not?

MR. STYKA: Yes.

MR. AJLUNI: Thank you.

MS. TURNER-BAILEY: Okay. Any further discussion, questions? Okay. Although it's been moved and supported that the Commission take no vote on 22209 -- based on 22209 sub (9), all those in favor --

MR. MAITLAND: So all those in favor means --

MS. TURNER-BAILEY: No vote.

MR. MAITLAND: -- we support a motion not to vote?

MS. TURNER-BAILEY: Right. A yes is a no. All those in favor -- we're voting on the motion. The question has been called. We're voting on the motion. I'm going to ask for a show of hands just to make sure we have a count. All those in favor signify by raising your hand. (Whereupon six affirm.)

MS. TURNER-BAILEY: One, two, three, four, five, six. All those opposed? (Whereupon five oppose.)

MS. TURNER-BAILEY: One, two, three, four, five. Carried by a majority vote.

MR. GOLDMAN: I would like to make one comment, if I can. This is Commissioner Goldman. We have voted on a motion that was predicated on legal advice from our legal counsel. We've also had two days of very detailed and very interesting public hearing. We've got a lot of information. It is clear from the legislative language that the Legislature was looking for some guidance from this Commission. We can't give them guidance by their desired June 15 date. But it would still be possible for us to do some work on the relocation issues, as Mr. Ball pointed out earlier, and provide to the State. It may or may not be in a timely fashion. And, you know, the question is whether the sense of this Commission is that we should offer to provide some guidance to the State about how to handle relocation of beds and the problem of changing demographics in areas like metropolitan Detroit. I don't know whether the commissioners are interested in doing that or not. I just feel badly that we've had so much testimony from so many people and we don't have the opportunity to do anything with it.

MS. TURNER-BAILEY: Well, I agree with that. And I don't feel like we listening don't have anything to do with the testimony. Certainly the fact that we didn't take a vote based on the advice of our legal counsel or at least from my perspective is not a statement about what the vote would have been had we done that, which is the reason I actually opposed the motion. I felt that we were asked for our guidance. The Commission was expanded with certain expertise and we were asked for our guidance. And I, for one, wanted to give that. Now, when you say give the Legislature guidance, I guess I would like to ask for clarification of what you mean.

MR. GOLDMAN: I'm not sure what I think it might be, because I'm not sure I know what the sense of the Commission is, and I don't know if we can or should determine that today without anything in front of us. What I think we ought to do is make sure that Mr. Ball's committee proceeds with the -- we couldn't pick on you every time, Jim. Why should this be different. I really think that -- I understand you'll have some stuff by the fall, you know, that would be better. But I think we should make an effort with the resources available to us from the department as well as from Mr. Ball's committee to see if there was a sensible position that could be formulated based on the information. I don't know what that position is. I'm not trying to express a position. I'm just saying the Legislature has to have some help. My concerns are that I don't want anything that we do to do damage to the Certificate of Need process itself. And at the same time, I want to be responsive to the needs that we have heard about. I don't know the right way to do that. There may not be a right way to do it, but I certainly would be interested in looking at options that are presented to us. And maybe the Legislature will say, you know, if you can't tell us by June 15th, we don't care. But that's out of our control. We can still provide some advice and counsel to them based on our best available thinking, but we haven't had a chance to do that thinking yet.

DR. SANDLER: Commissioner Sandler. We passed out language from the department to look at a standard about bed movement, Commissioner Goldman, a discussion of that which I think we've had for two days, although it did involve other things such as 3(c), which was more bed relocation. Wouldn't that in itself, comments on that, amendments on that, a vote on that, what have you, reflect what the Legislature are feeling?

MR. GOLDMAN: It might. What my concern is, if some of the speakers were correct and if inadvertently section 3 would allow the movement of thousands of beds. The figures have varied depending on who we have heard, but it was even under the most conservative estimate several thousands of beds. If that is the case and if the Legislature thought that they were allowing the movement of 200, 400, maybe 600 beds and instead they were allowing the movement of several thousand beds, I think that's something that we would need to comment on and advise the Legislature either of other ways to do that or of at least the consequences, perhaps unintended, by their actions in subsection 3.

MS. TURNER-BAILEY: Commissioner Breon.

MR. BREON: I guess I would just like to comment that I agree with that. I think that we ought to at least, if nothing else, advise the Legislature on what it is that actually we're voting on. And then also I think it's incumbent upon us to try to deal with bed relocation in some fashion. I would feel that we weren't doing what it is we were intended to do if we didn't address it, whether it was through the stuff provided through the staff or some other mechanism but at least address bed movement.

MS. TURNER-BAILEY: Commissioner Hagenow.

MS. HAGENOW: I voted no on that. I particularly voted no because I think the Legislature delegated to us something that wasn't an appropriate delegation. What they should have delegated to us is the standard setting around this movement. And so why don't we do that in an advisory way and presume that they are going to be smart enough to come along with that. I would feel that is what our obligation is.

MS. TURNER-BAILEY: Commissioner Ajluni.

MR. AJLUNI: I agree with the comments that have been made. And, Ron, I have another question going back to our vote? What's the rationale for, with all due respect to Mr. Corey, for saying that he hasn't been officially confirmed according to the AG's office but allowing him to vote on the issue since the vote was decided by one vote. What's the rationale for that. And I mean no disrespect to Mr. Corey, of course.

MR. STYKA: None of us do. We don't know him well enough. The same attorney general's opinions that I referenced clearly state that under our constitution, an appointee of the governor immediately takes their chair, their position and can immediately start doing business. What we were stuck with here is that for the very narrow purpose laid out in subsection 9, and that is determining whether or not to vacate basically subsection 3, there have to be the six new commissioners both appointed and confirmed. But as far as any other duties

under this Certificate of Need, Mr. Corey can act from the point that he was appointed by the governor as you could. So it's only under 9 as to whether or not to vacate 3 that he could not vote.

MR. AJLUNI: And 9 clearly spells that out?

MR. STYKA: Yes. That's what all the discussion was about.

MS. TURNER-BAILEY: Commissioner Smant. I agree with most of the comments that have been stated. I don't consider what we voted on today a position of policy. I hope that's not misunderstood in the Legislature that, in fact, we voted on this as a policy issue. I think we voted on a different issue. And possibly through the scenarios that have been addressed after the vote, we'll be able to more clearly identify that. But I also would want everyone to know that I appreciate all the time and effort you've put in. I appreciate the E-mails. I almost felt like an attorney for awhile. Your input is appreciated irregardless of what side of the issue you are on. I think we've all been illuminated. But never in my wildest dreams did I never feel that I would be involved in a constitutional discussion on our CON process. Thank you for coming. Thank you for your input. And I'm hoping that we can work through either standards or some communication addressing this issue with the Legislature.

MS. TURNER-BAILEY: Are there any other questions or comments? Commissioner Maitland.

MR. MAITLAND: I think that one of the reasons the Legislature gave us the ability, even though we have not had the ability to vote, is because they didn't have the time and didn't feel they were going to get all the input, in the short period of time they had to make a decision. I think we've had more input and we now have heard both sides of the issue. And I feel that certain sections of section (3) do do great harm to the healthcare system as asked for in the legislation. So I think we are obligated to pass that information on to the Legislature because we can't change it now. They have to make any changes. But I think we have enough information to make a determination. So I think if we voted -- and I'm not sure how that motion would be worded, but I think it goes along with Mr. Goldman wanting to inform the Legislature of our action, that we would indicate to them that there could be great harm done to the system because of parts of section (3). If someone has some suggestion on a motion, I certainly would support it.

MR. GOLDMAN: Again, we could -- if we wanted to do a motion, I suppose, it would have to be an advisory motion to the State Legislature that based on the testimony that we heard, there could be an independent consequence of 6C of -- 22209 sub C -- rather, 3(c) that would allow the movement of more beds throughout the entire state of Michigan than was evidently contemplated by the Legislature and that we as a Commission would be glad to look at the creation of a standard that would narrow the intent of section 3(c).

MR. MAITLAND: Maitland supports that motion.

MS. TURNER-BAILEY: Was that a motion?

MR. MAITLAND: Sure.

DR. SANDLER: Repeat the motion.

MR. GOLDMAN: For the purpose of moving this discussion along, I would be pleased to make the following motion. The motion is that we advise the State Legislature that as a result of our review of Section 22209 3(c) and based on testimony that we received, we believe that there could be an unintended consequence of 3(c) which would allow the movement of more beds than just a limited number of beds from the metropolitan Detroit area that we would be, as a Commission, happy to look at a standard that would mimic movement of beds and remove what we believe to be the unintended consequence of section 3(c).

MR. MAITLAND: Maitland supports.

MS. TURNER-BAILEY: I can't repeat that motion. I'm sorry. Commissioner Breon.

MR. BREON: Is this something that we would bring back in September or is that the timing of the process?

MR. GOLDMAN: We would need, in my opinion, some committee work and some departmental work to give us some material. We could, just as we have done recently, call a special meeting whenever we believe that we would have something to react to. I don't want to react to anything today because although the department gave us some language today, none of us have had a chance to read it or think about it. But I do think we could act as soon as we had some substantive material that was available to us, and it doesn't have to wait until September.

MR. BREON: I was advocating we wait until September. I think we're going to -- on the west side of the state, I think we're going to have to look at what the implication of all this is. I think we're going to need some time to evaluate it. I certainly think we would probably support the new language. But I think -- we've got it. We should probably digest it first.

MS. TURNER-BAILEY: And there are copies available here; right, Jan?

MR. CHRISTENSEN: I think the only difficulty with the waiting until September is that with the action that you've already taken today, you've opened up 3(c). And my colleague, Larry Horwitz, would contend that what's 10,000 beds, using his numbers in play. And it potentially does. Our own analysis is that it's about 84 hospitals and about 15,000 beds in total. The action you already took today allows about 5,000 beds to move within the subarea. So there's all of those moves that are going to happen anyway. The reason the department proposed the standard was to try and recognize the dilemma that 3(c) presents for the State of Michigan and the CON process. And if we can meet what is the narrow legislative intent -- when all this started in December, I think what they were attempting to accomplish -- and I see that Steve Ehardt's letter, which was presented to you, reflects the fact that the intent was that the three systems would be allowed to a limited transfer on a one-time basis to hospitals. That amounts to a total of, depending on whether you calculate the 10,000 number that Larry Horwitz used under 3(c) -- and I will say it's at least that. But that would amount to, if you transferred 750 beds, about 7 and-a-half percent of the potential transfer that's out there. If we want the Legislature to move definitively -- and this is one person's judgment against 110 reps and 42 senators, and it all works out differently, but you've got some of the letters that have been submitted. If we want the Legislature to move definitively to close down the hole that we currently have in 3(c) -- and I think there's good reason to do that -- and to close it as quickly as possible, if you want that to happen legislatively, that's the best way for it to happen. If you want them to do that, it's the department's belief that the way you maximize the potential that they'll take definitive action is to carry out the limited legislative intent that they've presented and they've been pretty clear about in terms of what they are trying to accomplish. If we go back into the Legislature on dialogue about closing 3(c) down and talk about a long-term process of figuring out bed need standards, they won't do it. At least they won't do it quickly. There'll be enough debate back and forth to close that down. And as it stands right now, it's wide open. If I can take just another minute.

MS. TURNER-BAILEY: Okay.

MR. CHRISTENSEN: The question was raised by one of the attorneys -- sorry, I forget my fellow counsel's name -- but do we have the ability to put a standard out, a draft standard. Does this Commission have the ability to put a draft standard out for public comment and public hearing and begin that process. In light of the fact that 3(c) apparently provides a wide-open authority and so the standard would be a restriction of that authority and is that permissible. 3(c) doesn't take effect until June 15th. You have the ability today to pass out a standard, a draft standard, for public comment on June 10th consistent with the current state of the law. And I believe your counsel will confirm this interpretation. You have the ability to pass the standard out for public comment and review. We drafted the standard in such a way that it does accomplish a very limited transfer. And we're not saying it's a hundred percent perfect in terms of its wording. It does affect the three units involved, the Henry Ford, St. John, and Detroit Receiving. It does provide for a one-time transfer for each of them. We think it works. And if you pass it out for public hearing, you at least can say to the Legislature in good faith, we heard you on your intent; we need your help to close down what you actually did with 3(c). If you simply let it go, 3(c) is wide open. And the transfers will happen anyway, the three transfers that you are thinking about, and it's less likely that you'll get the kind of response that you want in a timely way. We know some people will oppose shutting 3(c) down.

MS. TURNER-BAILEY: Commissioner Sandler.

DR. SANDLER: I appreciate the intent of your remarks. I'm having some difficulty voting on something that I haven't currently studied. I'm having some difficulty on that. If you believe one analysis that has very little potential because one would not move beds from a hospital that's 50 percent occupied a couple miles down to another one 50 percent occupied, there may not be as much potential. I'm having some trouble, however, voting on something. Is there any change in the language, Jan? If you tell me yes, you look like an honest guy and I'll believe you. But I'm having some difficulty passing something without having further studied it and bounced it off other people.

MR. CHRISTENSEN: I thoroughly appreciate the need to study the standard. And if we did pass it out at the May 28th hearing, there are a handful of changes to that standard that I could describe today. But if the sense of the Commission is to take some time to look at that standard in depth, that's, of course, an appropriate thing to do. But I would argue against waiting until September, because I think the gain is gone by then for sure.

DR. SANDLER: Okay.

MR. DELANEY: Does it at least makes sense to pass a resolution today to provide guidance to the Legislature that what has occurred as part of 3(c) is not what we believe their legislative intent was and that we will be revisiting that issue soon to try to provide direction as the Commission sees it?

MR. STYKA: Well, you always have the authority to pass a resolution.

MR. DELANEY: To be on record.

MR. STYKA: To be on record, send a message. We dealt with that issue a couple years ago. And clearly I advised you at that time that the Commission can do such things, take a position on an issue through a motion process and resolution. So that should not be a problem.

MS. TURNER-BAILEY: Commissioner Smant.

MR. SMANT: Do we need to approve the standard prior to putting it out for public comment?

MR. STYKA: If you're going to deal with the standard that the department provided you, ironically -- again, repeating this law and all its twists and turns, I have given advice that the application of 3 (a), (b), and (c) does not occur until June 15th at the earliest, which means that for a few days now you actually can still adopt standards, although the process doesn't allow it to happen that fast, with regard to these hospital movements because they're not yet exempt from CON. You could begin a process, I suppose, of adopting standards for purposes of putting it out for public comment. But very quickly, you will no longer have authority. And that could be meaningful in terms of whatever you want to say to the Legislature, I don't know. That's up to you. But, I mean, that is a process that's possible. But once the 15th comes, although the comment may come in, at that point there is an exemption of 3(a), (b), and (c).

MS. TURNER-BAILEY: But the fact of the matter is you said we have the authority to start the process, but there's no way we can get through the whole process by the 15th no matter what we do.

MR. STYKA: That's correct. Unless at some point the Legislature changes what the law says right now, you would have begun it, but it will die, so-to-speak.

MS. TURNER-BAILEY: So what would be the harm of -- following through with some of the earlier thoughts -- of saying we have this language, we think we can and should look at this issue through the CON process? And maybe that's more my personal thought about this, which I think has sort of gotten lost in this whole discussion, which is the fact that we need to maintain the strength of the CON process. And if we do a resolution, I would hope that we would start by saying that. If we say we would like to handle this issue in the context of CON and we have some draft language that we would like to hear a response and possibly act on in some way whether it's to put it out for official public comment in the September meeting, whether we have a special meeting between now and September to gather that input with the intent of following through on that in

September, would it change the status of the way things are right now, understanding that we can't get final action on anything before the 15th?

MR. STYKA: I'm trying to understand what you were asking me, Renee.

MS. TURNER-BAILEY: Does it matter if we do it now or take our time, a little bit of time?

MR. STYKA: Well, the difference is right now is you do have authority for a few more days to actually deal with this section. But after the 15th -- or on the 15th, you no longer have any authority in this area, because the Certificate of Need law is a law predicated on the need for a Certificate of Need. And 22209 says, you know, except that's provided in here, you need a CON to do all these things. Well, the exception is, which will go in effect, you know, in a few days, that you don't need a CON for these areas. You can't adopt a standard on something for which no CON is needed. So you could begin a process. It will die by virtue of the fact that the law will no longer allow you to deal with it. But if that is somehow helpful to you, I suppose you can begin it. I don't know. The policy is not my reason for being here.

MS. TURNER-BAILEY: We can't adopt a standard before the 15th?

MR. STYKA: No, you cannot.

MS. TURNER-BAILEY: So beginning a process or --

MR. STYKA: I don't know what benefit it has. That's up to you. I don't know.

MS. TURNER-BAILEY: There's the answer that I was -- Commissioner Sandler.

DR. SANDLER: We have a number of important issues. I don't mean to hurry anyone. We do have a number of important issues, so is it possible to -- as a point of order, to bring this to closure one way or the other so if I have a kidney stone, it might be -- it's already past 4 o'clock. And there are some very important issues here. I would urge my fellow commissioners and the chair to decide what to do and to bring it to closure and move on.

MS. TURNER-BAILEY: Thank you.

MS. HAGENOW.

MS. HAGENOW: In spite of the time, I think it's very important, because what we're talking about is the value of the Certificate of Need. And if there isn't some waiver and no importance, then if we don't do something, even if it's just advice and counsel and giving it to the legislator -- legislative branch, it's important, I think, that we're saying that here is our -- we're putting it out there for public hearing. Even if it dies, it's the message that we're sending that the Certificate of Need should be honored and that standards are underway and ask the Legislature to take that into account. Maybe they will do some special action or something. I think it's just important that we just not sort of say, well, we took this vote, and that will become the opinion of our sense of the whole issue. And I think we are all in agreement around the Certificate of Need being important and that it should not be some big open door to franchises and disempower the Certificate of Need forever.

MS. TURNER-BAILEY: We have a motion on the floor. In the meantime -- I'm sorry. Commissioner Corey.

MR. COREY: Recognizing that we have no authority after the 15th in terms of the standard, I think that it would behoove us to recommend the standard in spite of that so that a clear message is sent to the Legislature on how we feel about this whole thing. In absence of doing that, that message would not be conveyed; and I think it would present a danger for this proliferation of beds that could potentially happen. So I would recommend that we develop a standard in spite of our lack of authority to do it on a recommended basis.

DR. SANDLER: I would like to call the question. Was there a motion on the floor? So I would like to call the question on the motion.

MS. TURNER-BAILEY: Is everybody in favor?

MR. STYKA: You have to vote on the question.

UNIDENTIFIED SPEAKER: Madam Chairperson, it's a proposed action. Every time you take a proposed action --

MR. SMANT: There's no discussion at this point because the question has been called, and we have to vote on whether or not to close discussion. So we really can't hear from anyone here or out there.

DR. SANDLER: Thank you. Can you repeat your motion, please, Commissioner Goldman.

MR. GOLDMAN: The motion was to -- and I'll paraphrase it rather than repeat it. The motion was to suggest to the Legislature that we have heard substantial public testimony, that as a result of that testimony, we believe that there is an unintended consequence in 22209 3(c) which could allow the movement of many more beds than the Legislature had intended and that we would be willing to provide advice and constitute the Legislature on how to correct that unintended problem.

MS. TURNER-BAILEY: So that would be a letter or a statement?

MR. GOLDMAN: Well, if that is accepted, then somebody can make a second motion. And that second motion, for example, as Commissioner Hagenow pointed out, could be to adopt this proposed standard and send it out for public comment. And we could then get the public comment. And based on that, we could -- that would give us time to actually read and absorb this. We could then have a special meeting as soon as public comment was over, and we could adopt for final action a standard for consideration by the State Legislature. That would require the State Legislature -- because by that time, it would be after June 15th -- to amend their legislation, which they should have the ability to do.

MR. STYKA: You wouldn't be adopting; you would be proposing.

MR. GOLDMAN: Proposing. You're right. That's the motion.

MS. TURNER-BAILEY: All those in favor signify by saying aye. (Whereupon all affirm.)

MS. TURNER-BAILEY: Opposed? Abstained?

MR. GOLDMAN: I have a second motion. Perhaps Norma does.

MS. HAGENOW: No.

MR. GOLDMAN: Given the fact that we are concerned about the current unintended consequences of 22209 3(c) as presently written, I move that we adopt the Certificate of Need review standards for hospital beds given to us today by the Michigan Department of Community Health and send those forward for public hearing. This is a proposed action that we take -- instead of adopt -- that we take a proposed action to send the Certificate of Need -- to adopt the Certificate of Need review standards for hospital beds and send them forward for public hearing.

MS. TURNER-BAILEY: It's been moved that we put the language that's been presented by the department for a proposed action, supported by -- moved by Commissioner Goldman, supported by Commissioner Delaney. Any discussion?

DR. SANDLER: Mr. Christensen is an honorable man, and so I take him on his word.

MS. TURNER-BAILEY: Any further discussion?

MR. MAITLAND: As part of that, I would propose that we consider -- and I don't know if as part of this motion -- but all of us having a special meeting of all of us to hear that public input, and then at that time we could still take action. Basically it would be -- the public hearing would be in front of the full Commission, which I think is allowable. I, as chair, sat at a couple public hearings. And I think that we have to move quickly with this. And I think 30 days is -- it has to be at least 30 days?

MS. ROGERS: It has to be 30 days.

MR. MAITLAND: So I would support this motion, you know, and then I'll come back and say that we should have a special meeting for that hearing.

MS. TURNER-BAILEY: My concern -- I have a couple cards, and I hope we can hear it. But I have a concern that we haven't heard from the public on this standard, that we're actually putting forth -- we're putting forth a proposed action before we hear from the public. Yes; we can make changes after the public comment period, but we don't have -- I'm going to assume those changes would not be wholesale changes, that they would be, you know, technical changes, those kinds of things. And that is my major concern about putting forth a proposed action at this time, because we had -- I'm willing to schedule a special meeting to hear that and at that time move forward with public comment. I think that would be appropriate to do. And then we can make sure we've all had a chance to review it, look at it. And we could make sure that we've had a chance to hear the public on the issue and move forward for a proposed action at that time. That would be my preference.

MR. STYKA: I just want to remind you that starting the 15th, you don't have authority anymore with regard to 3(c). So you wouldn't be able to do what you just described. Also, I would like to point out that the Legislature seems to have contemplated changes to section 22215 that you now have a two-meeting process.

MS. TURNER-BAILEY: You mean proposed action, final action?

MR. STYKA: Yes. With a public hearing in between. It's a much quicker process than we had prior to --

MS. TURNER-BAILEY: Yes. I understand that. And if -- and probably moving forward, what will happen is we'll take public comment before we take proposed action on an issue, whatever that happens to be. Right?

MR. STYKA: That's true.

MS. TURNER-BAILEY: Which we never have done. Yes; I can see that. You would take the public comment and do the proposed action all in one meeting. But what we are talking about is skipping the public comment and going to the proposed action. Yes, we are. We have to do that; right, otherwise, it's not -- it's meaningless is what you are saying is what I understand.

MR. STYKA: I think the public is here, plus the public hearing is the opportunity for public comment.

MR. GOLDMAN: What I would suggest, just to be clear, is we start the ball rolling today. We schedule a public hearing for the usual standards, that we have the public hearing. And that we can, of course, attend the public hearing if you wish or get a written report of the results of the public hearing and that we then have a special meeting, which could be as Jim points out, as early as the same day of the public hearing or could be sometime after the public hearing. I am as concerned as you are, Renee, about this. And I would not have made this motion but for the fact that it's the 10th, and we have only between the 10th and the 15th when we can take a legally valid action. That's the only reason I'm trying to proceed in this unorthodox fashion.

MS. TURNER-BAILEY: Well, in that case, I'm going to take some public comment.

DR. SANDLER: Do you wish to pass the standard today, set it out for a public meeting and then revisit it in September for final action?

MS. TURNER-BAILEY: That's what we would have to do.

DR. SANDLER: Is that what you are asking?

MR. GOLDMAN: I wish to propose the standard today. My motion was to propose the standard today, to set that standard up for public hearing. Following the public hearing, at a convened meeting of this Commission, which could be on or before September, because we could do it at a special meeting, to then decide whether we want to take a final action.

DR. SANDLER: The final action would be the September 19th?

MS. TURNER-BAILEY: Brenda --

DR. SANDLER: I would like you to clarify. Thank you, Jim.

MS. ROGERS: This is Brenda Rogers. Again, just to clarify at whatever date you take proposed action, whether it's today or some other day, then from there, we will schedule the public hearing. You cannot take final action, if that's what you decide to do, until -- there's got to be 30 days in between the public hearing and final action, just to clarify that for you.

MR. GOLDMAN: And one other point, because it will at that point be past June 15, we will not, as a Commission, have the authority to take a final and binding action other than to forward to the State Legislature our proposal for how they could make changes to their law should they wish to do so.

MS. TURNER-BAILEY: Patrick O'Donovan. While Patrick is coming forward, I've been asked to ask you to keep your conversations down. It is a little disturbing to the court reporter and others. Thank you.

MR. O'DONOVAN: Thank you, Madam Chairperson and Certificate of Need Commissioners.

MS. TURNER-BAILEY: Excuse me, Mr. O'Donovan. We are going to limit the comments on this to a very short time period, two minutes. Thank you.

MR. O'DONOVAN: I understand.

MS. TURNER-BAILEY: Go.

MR. O'DONOVAN: My name is Patrick O'Donovan, director of planning for Beaumont Hospital. With regard to these brand new standards that were passed out to the Commission and some of us in the audience have, there has not been any opportunity to have public comment on these proposed standards. I've been involved with the Certificate of Need Commission and all of you for many years. And that's always the case that we do have an opportunity to comment even on proposed standards, which you're suggesting today that that would not be the case, to have any legitimate comment on these standards. The case was made that there are a lot of problems with 3(c) so, therefore, we ought to act to pass standards or pass proposed standards that speak to that. Most of the comments that I heard today related to 3(b), and that's not being considered at this point. I think that the Commission really has not weighed in on either issue, 3(a) or 3(b). So to say that the proper course of action is to challenge 3(c) through standards I'm not sure is appropriate. As Mr. Goldman pointed out, I don't see what urgency there is to pass even proposed standards today. The point that come June 15th you're not going to be able to act on proposed standards is also the case for final standards. So with regard to 3(a) -- or 3(b) and 3(c), those are going to go into effect, and the standards are not going to -- any passed standards that you pass from a proposed action today, you won't be able to take final action on after June 15th. So I just ask the Commission to consider those points. Thank you.

MS. TURNER-BAILEY: Thank you. Any questions for this comment? Okay. Thanks. Larry Horwitz, Economic Alliance.

MR. HORWITZ: You made your decision on the first point. If you want to use the proposed standard as a way of communicating to the Legislature what they should have done different on anything, you've got to do it before Sunday.

MR. Styka and I agree. The 30-day issue is not between today and the public hearing. The 30 days comes between the public hearing and your final action. So you could have another meeting of this Commission between now and Sunday -- not on Sunday, but between Wednesday, Thursday, Friday, and Saturday. It's the only interval of time in which you can communicate to the Legislature by taking proposed action. Proposed action under the new statute, what does that mean? It's not sending it to public hearing. It is also sending it to the joint committee -- newfound joint committee of the Legislature on Certificate of Need. This means that you are making a considered judgment that whatever's in these sheets of paper that the department has passed out are your recommendations. If you just send them any ole damn thing you wanted to that you haven't even read, don't know what's in it or anything else, you are -- in the very first time this joint committee will ever function, you are basically saying that we don't care what you think or what you say; we're just sending out any old damn stuff, and then we'll tell you what we really want. They take very seriously that the Joint Commission -- and chairs and vice chairs of the two committees of Public Health are supposed to be overseeing what you do. Well, then you've got to make a considered judgment on what you want to do. In my judgment, this doesn't do what the department says it's going to do. How do I know what the department says it going to? Because Jan told me privately. They didn't describe to you what they think it does. This document on page nine says the transferring of hospitals gets to send 35 percent of its beds someplace. Well, there are in Detroit something like 12, 14 hospitals. So each one of St. John's three hospitals, Henry Ford's one hospital, and the five, six DMC hospitals can each send 35 percent of their beds out. That's where we get the1,200 number. That's way more than the department wants to have happen. That's way more than the Legislature or that Representative Ehardt says he wanted to happen, that we distributed this letter from Representative Ehardt that he E-mailed late last night, so I doubt too many saw it. So what I'm suggesting to you is that the way you want to make a considered judgment and say, well, here's the fix on 3(b), here's the fix on 3(c) and, by the way, what do you want to do about 3(a), which no one has ever talked about, you can only do that if you have a meeting -- if you only want to do that between -- by submitting a standard, you've got to submit the proposed standard between now and Saturday midnight. And to do that with any respect for the Legislature, any process, you need to go -- have public comment, either stay here late tonight or come back in two days and hold a meeting or, otherwise, you're really denigrating this whole process. The department intends that this be a restriction per system, but that's not what it says. The department says it intends to do some other things, but that's not what it says. And it's still saying hospitals all over the state of Michigan can do this stuff. St. Mary's - Saginaw can do this because they got a connection with the hospital in Detroit. They are both owned by Ascension. That's way beyond what anyone has said they wanted to do. I urge you not to take proposed actions. I urge you, if you want to do something, to call another meeting the next two or three days and tell everyone get yourself in here and make comment and then decide if you want to take proposed action.

MS. TURNER-BAILEY: Thank you. Any questions? Oh, Brenda stepped out. I wanted to ask her about the process as described and discussed, unless you want to talk about it, Jan.

MR. CHRISTENSEN: There are several issues that, of course, I don't agree with. I think this proposed standard does reflect actively a limited transfer on a one-time basis. Larry has an issue, and I've talked with Larry about it, the legislative intent 200 beds or 300 beds. And we saw Representative Ehardt's letter passed around earlier today by a previous speaker that said approximately 200 beds for the two health facilities. And the subsequent Representative Ehardt letter is one of the chairs that you are going to be sending this standard to saying that it was his intent that the Legislature -- it's his understanding of the intent that there would be a limited transfer from three hospitals. The thing that the standard doesn't have is a fixed number for the total number of beds, that should be an issue, I think, for public comment when you put it out for public hearing and a determination made whether it was 200 beds or 250 or 300. We did hear substantial testimony over the last day -- today and on the 28th about the proposed transfers by Henry Ford and by the St. John System and some references by some speakers to the Detroit Receiving possibility in terms of transfer. It's not as though significant numbers of folks haven't known that this was a proposed standard and a proposed recommendation by the department. In fact, we did pass the substantive standard out on May 28th. We think it is important to take action on this proposed standard to say to the Legislature we are concerned about your intent and we need your help to fix the problems of 3(c) and then, I guess, we also need your help to stay out of the CON process in the future so that the Commissioners can exercise the process that was intended under the statute.

DR. SANDLER: I have a point of order. I would like to call the question.

MS. TURNER-BAILEY: There's no other cards for this.

DR. SANDLER: Call the question.

DR. YOUNG: Is it possible that we can meet in two or three days at all?

MS. HAGENOW: Again, I know this is an unusual circumstance, but do we not think that the power of the Certificate of Need process in the state is important, important enough that we should indeed come back on Friday or whatever to be clear about what we're supposed to be doing, which is setting standards, not doing a veto on an administrative rule?

MS. TURNER-BAILEY: I believe it is.

DR. SANDLER: I'm uncertain what the issue is as to we have a standard that appears to answer the unintended consequences of 3(c) in front of us. And, therefore, it's unclear to me why we're having another meeting. If we pass this standard, send it to public comment, and then have a meeting to pass it, the Legislature isn't going to do anything in the summer. It isn't like they're waiting for us.

MS. TURNER-BAILEY: If they aren't going to do anything, we can't do final action anyway.

DR. SANDLER: And those of us who have some patient-care responsibilities, it's going to be very difficult for me to come back -- although I love all you at the Holiday Inn -- to come back in a few days when it isn't going to change anything.

MS. TURNER-BAILEY: Well, I can tell you my thoughts on that. I'm caught when you say appears to answer the issue. That's what's concerning me. I want -- I need -- I'd like to hear, you know -- in my opinion, one important part of this process, which I don't think we want to get rid of, is hearing from the public, hearing from those who are affected by issues and hearing from experts. And I am concerned about skipping that step. And that's what we're doing.

MR. CHRISTENSEN: Then you could call a special meeting of the Commission, giving us a few weeks to make certain our schedule could accommodate it. There's nothing wrong with that.

MS. TURNER-BAILEY: Which doesn't help the situation, because it's sort of before the 15th or it doesn't matter.

DR. SANDLER: It doesn't –

MR. YOUNG: If we have a meeting before the 15th, we can make some proposed changes.

DR. SANDLER: I missed this point. Maybe the assistant attorney general can help us with this. This meeting before the 15th would accomplish what?

MR. STYKA: I don't know.

DR. SANDLER: I don't think it makes any difference a week before the 15 or if you don't make the 15th.

MR. STYKA: Timing wise, I mean, there's no way you're going to be able to adopt a final standard.

DR. SANDLER: Correct.

MR. STYKA: You either can send a message to the Legislature in the form of some sort of resolution, which apparently you talked about already. And then there's a suggestion -- and it's a good one -- that another way to do it is send a resolution that includes here's the standard that we would like to adopt. I suppose you could do that whether or not you do all this process, if that's all you're going to do.

DR. SANDLER: And whether you do it before the 15th or not is not going to be a relative point. The Legislature isn't going to do anything for a period of months. I mean, they will get to this at the earliest in the fall. I can't imagine that anything is going to be done. So I'm not certain why we need a special meeting.

MS. TURNER-BAILEY: Is there a motion? I completely forgot. Sorry.

DR. SANDLER: And you didn't call the question.

MS. TURNER-BAILEY: Can you repeat the motion, Commissioner Goldman.

MR. GOLDMAN: The motion was to adopt as a proposed standard the Certificate of Need review standards for hospital beds given to us today by the Michigan Department of Community Health, and the rationale for doing that was our concern about the unintended consequences of section 3(c) as we've heard in testimony today.

DR. SANDLER: I believe I called the question on that.

MS. TURNER-BAILEY: And the support was from --

MR. GOLDMAN: The rest of the motion was to move to a public hearing on the proposed standards.

MS. TURNER-BAILEY: And the support came from Commissioner Delaney. Okay. You heard the motion. All those in favor signify by saying aye. (Whereupon some say aye.)

MS. TURNER-BAILEY: Opposed? (Whereupon two oppose.)

MS. TURNER-BAILEY: Two opposed, for the record.

MR. MAITLAND: Maitland has a question. I think that maybe we're going to make some major changes to this after it goes to public hearing from what I've heard so far. There's no problem with that. If we make major changes, then do we send it back to that legislative review committee and say, hey, we made some major changes and say we want you to review it again? That's not addressed. Do we only send it to them once?

MR. CHRISTENSEN: If you make major changes to it, when you make your final decision, your final motion on the standards -- and you can only do that if three is infirm somehow. As Attorney Styka has pointed out, if three is alive, you've got a problem. But if three is infirm as a result of a lawsuit or legislative appeal or whatever, then at that point you can make a final standard. If you make a final standard, it goes back to the Legislature for 45 days. They have 45 days to approve or reject it.

MS. TURNER-BAILEY: We are going to now move to agenda item eight, PA 619 sections requiring CON Commission action. Believe it or not, there's other parts of PA 619. Let's see. We don't have any cards. Jan, just for clarification, you said there were copies of the standards here. Did everybody know that and where they can find it?

MR. CHRISTENSEN: They are on the back table in a box. We put them all around.

MS. TURNER-BAILEY: The commissioners, I know, have received them. So if anybody is interested in a copy of the proposed standards, they are in a box on the table in the back of the room if you haven't already picked them up.

DR. SANDLER: Jan, is this the one that has your changes in it that was passed out today?

MS. ROGERS: It was the one that was on your chair after lunch.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: You may recall from several meetings ago that Ron Styka passed out a list of items that the Commission needs to take action on under PA 619. Now we have a new one that was passed out today, I think, with dates included. And we just need -- we need to have some discussions about priorities. We also have some suggestions from the department about how we might be able to move some items forward that we don't think require meeting after meeting to take care of, that they might be able to do some footwork on in a short-term that we might be able to take action on in September. So, Brenda, I'm going to ask you to elaborate on that piece of this issue.

MS. ROGERS: Again, Brenda Rogers. Just to let you know, in your packet of material that was distributed this morning, we kind of -- we've given you a table of those items that Ron had initially given to you -- can you hear me now? The table that was given to you this morning, basically the layout of that table, again, identifies those major items under 619 that the Commission needs to look at, gives the subsection of the statute and, in one case, the section of bylaws that indicates where you need to take action on. The way the table is set up, we set it up by date. So it's kind of in the order of what needs to be acted upon first. But the Commission is free to make changes, that type of thing as far as setting your priorities. We've tried to outline it by date, and hopefully that will be helpful for you.

MS. TURNER-BAILEY: So the action that we need to take on this is just agree with the time line or what do we need to do? Say this is great?

MR. SMANT: Brenda, should we start working towards the October 2003 on 22215(1)(o)?

MS. ROGERS: Yeah. I mean, the department -- yeah. I mean, we're going to need some guidance from the Commission. Obviously you have a lot of different areas that you need to act on. So I guess that would be what things do you want to start working on. What do you want the department to start assisting you with as far as these items go. Again, like I say, the next one, if you look at the table, is the 22215, looking at the hospital review standards. That's the next one that has an actual, quote, "deadline date." It says within six months. Our best guess is about October, somewhere in that time frame.

MR. SMANT: Should we ask the staff to develop a process that they could send to us that we can begin working with and determine how we want to go as to how you want to follow each of these?

MS. ROGERS: Well, I guess it's going to be up to the Commission. As far as like this next one, the 22215, as far as the hospital review standards, as you know, the statute made a change there, so an ad hoc is no longer a mandate. And the Commission could choose to act on this issue on its own. It can refer it to a standard advisory committee or consultant. I mean, those are your options in looking at this. Another part of that would be to ask the staff to help in the development of whatever changes need to be made.

MR. SMANT: Okay. Thank you.

MS. TURNER-BAILEY: Are there any questions on the work plan, the dates?

MS. ROGERS: In addition to -- in addition to -- again, this is Brenda. Again, we had some discussions and we talked to Renee about a possible pilot project through the summer to hopefully deal with some of these other issues for the Commission. What I'm going to pass out is a draft proposal that would allow the department to start working on some of these issues as far as the standards go. On your agenda for today, as you know, you do have the surgical, you have CT, you have MRT, and you have litho. Again, what we would like to do is -- looking at this, what we would propose is that the Commission appoints a liaison to work with the department. What we would then do is set up public hearings to take testimony on the various standards. Each standard would have its own public hearing, okay, so they would not be combined. That would allow us to get input from the public on what changes need to be made to those standards, maybe some suggestive language, that type of thing. From that -- and in addition to that, if the Commission so desired, we could impanel an informal work group of experts to also help us in this process.

After we hold a public hearing and we receive the testimony, then the department -- and this would probably be an ongoing thing. But we would be doing our literature review based on the testimony that we received on those standards. And, again, we would attempt to, after all of the review, working with the Commission liaison

and working with that liaison throughout this process where that liaison could be going back to the Commission members at various points or they might be getting input from other outside experts and getting information back to the department as well, from there, we would draft some language to bring back to the whole Commission. We would ask that since the Commission liaison was working with the department at that point, they could give the report to the Commission and, you know, give either at that point a thumbs up or thumbs down, so-to-speak, as far as the draft language goes.

And then assuming, if the Commission decided to take proposed action, they were in agreement, you know, on the language, could take proposed action and would go through the same regular process. We then schedule a public hearing, final action. Hopefully that would speed things up a little bit.

In addition, if the Commission decided no, we need more information, we realize all the work put into it, but we still need more information, there still needs to be other changes taken into consideration, then at that point the Commission again could direct the department -- depending on what those changes are, direct the department to go back, make those changes and/or at that point seek a standard advisory committee or other outside consultants so you would still have that available to you even throughout this process. And, again, you could also take additional public comment at that meeting before you would take proposed action.

Like I say, what we are attempting to do is hopefully speed up the process without -- and still receiving the public input.

MS. TURNER-BAILEY: Just for clarification, there would be a different liaison -- you may have said this -- for each standard?

MS. ROGERS: That's correct.

MS. TURNER-BAILEY: And you could hold joint public hearings if you choose to.

MS. ROGERS: Yes. You could if you wanted to depending on how -- on how many issues you are actually looking at. If you know up front that okay, just initially a set of standards, it looks like it's going to be a narrow issue, possibly you could do a public hearing at the same time.

MS. TURNER-BAILEY: Are there any other questions on this procedure, any comments?

MR. SMANT: My only comment is this addresses what I was asking previously.

MS. HAGENOW: I guess I'm wondering how long it's going to take to go from beginning to end to do this.

MS. ROGERS: It really varies. It's the logistics of getting the committees set up, contacting the -- sending the nomination letters out and getting all that back, getting the approval through the chair. So it's the logistics of getting the actual -- now in this case it would be the standard advisory committee but was previously the ad hoc committee, it's the logistics that are involved. So hopefully if we can eliminate that process, that would be some time saving right there.

MS. HAGENOW: I'm just thinking that as you have listed -- shouldn't there be time lines? I mean, just listing one through -- or bullet points is going -- it doesn't seem to me to have any accountability to expediting this.

MS. ROGERS: Again, this is just -- this is a draft proposal that we put together. We're looking at this as a pilot project through the summer. And if this works, then hopefully, you know, the Commission could adopt this procedure for future use. And/or if we see that changes are going to need to be made to this process to maybe fine-tune it, we could do that. But our goal is to try it through the summer. And our goal would be to at least have held all four public hearings and that by the September meeting at least come back with draft language for at least two of the standards, possibly all four, but at least for two, but have held the hearings and so those standards are also in the works at the same time.

MS. TURNER-BAILEY: Right. We still have a work plan that guides us in terms of time lines, too.

MS. ROGERS: Yeah. And that would be the one piece that we would need from the Commission. Once we get to the part where we're drafting the language, which standards do you want us to do first, you know, that's where the Commission is going to have to give us some priority.

MR. STYKA: If I could make a suggestion, one of the things that the Commission needs to do is revisit the bylaws to make sure they're consistent with the laws that have been changed by Public Act 619. And I would be willing to make an attempt to try to do that. And if you'd like, we can also attempt to include that as a bylaw, this kind of procedure. And that way, you know, you can look at it and discuss it at your next meeting and see if that's where you want to go. And by that time, you would have the experience.

MS. TURNER-BAILEY: Okay. I think that's acceptable. We don't need a motion for this, do we? This is more of a discussion item? Okay.

MR. STYKA: No.

MS. TURNER-BAILEY: Okay. Good. Thank you, Brenda.

MR. MAITLAND: Madam Chair.

MS. TURNER-BAILEY: I know. I just want to ask a general question before you make your motion. In light of the discussion that we just had with the department with regard to gathering some of the information, doing some of the leg work for us for some of these standards, that connection would help us, I think, for many of these agenda items that are coming up because you talked about four, which I assume include these four that are on the agenda. So since we've agreed to the pilot project -- since we agreed to the pilot project, I think we can -- I believe we are in a position where you could gather the comments -- maybe I'll give you the cards of the people who wanted to speak -- and deal with these agenda items in September. Does that seem acceptable?

DR. SANDLER: I apologize, but I'm not certain what you're suggesting. Are you suggesting that we are not going to consider any more of these agenda items?

MS. TURNER-BAILEY: I'm suggesting that it's possible that our pilot project will help us in terms of gathering public testimony and other background on CT, MRT, surgical services, and UESWL.

MS. HAGENOW: Those were not actioned?

MS. TURNER-BAILEY: Right. Those were not actioned today.

DR. SANDLER: I think the CT could be expedited greatly by a few comments based on some preliminary discussion I had. It wouldn't take more than a few minutes. I'm told there's more to it.

MS. TURNER-BAILEY: It's 5 o'clock already.

MR. MAITLAND: I think we have about two or three hours more of work to do to finish this agenda to give it the attention that it needs. I would move that we table the balance of the agenda and direct the chair to set up a special meeting in July to finish the balance of this work. I, too, would like to move forward with CT, but I've sort of lost contact of what we're doing right now, thinking about other things. My motion is to table to special meeting in July.

DR. SANDLER: Does the department supply dinner if we continue?

DR. AJLUNI: Could we handle those in the September meeting, because July is a tough month for everybody, I think.

MS. TURNER-BAILEY: The motion is that we table the remainder of the agenda and that we attempt to schedule a special meeting in July. And I have to take a vote on that motion.

DR. AJLUNI: May I ask, Mr. Maitland, considering my comment that July might be a tough month for people, would you consider revising your motion to making it in September? Do we lose anything? Are there any of these critical issues that have to be decided --

MS. ROGERS: Your next regularly scheduled meeting is September, September 9th.

MR. MAITLAND: My motion was to try to set up a special meeting in July. I think we have to start addressing these issues before September, but I don't think we have time to address them today.

DR. SANDLER: If that motion carries, the only thing that I would ask -- that's fine -- is that the department almost immediately distribute a number of days to see, because there's a lot of times we're not going to be here. I'm going to be in Traverse City part of the month.

MR. MAITLAND: Playing golf.

MS. TURNER-BAILEY: I propose a meeting in Traverse City.

DR. SANDLER: And give us a choice day so we can see the dates that most commissioners can make.

MS. TURNER-BAILEY: I think we absolutely would do that.

DR. SANDLER: Please.

MS. TURNER-BAILEY: We have at least to have a quorum.

DR. SANDLER: I realize how busy you are. Could you do this ASAP? I mean, I've got scheduling for July, patients, blah-blah-blah.

MS. TURNER-BAILEY: All those in favor signify by saying aye. (Whereupon all affirm.)

MS. TURNER-BAILEY: Opposed? The meeting is adjourned. It's 5 o'clock. (Whereupon the proceedings were adjourned at or about 5 p.m.)